



Exclusive Care Select Health Care Member Claim Form

Instructions for submitting this claim form

1. Use a separate form for each eligible family member who has received services.
2. Attach an itemized bill from the provider of service including diagnosis, procedure numbers or descriptions of the service, charge for each service, date of each service, providers Federal I.D. number.
3. Complete all information requested on this form and provide the necessary signatures. **If necessary information or signatures are missing, your claim will be returned to you.**

Mail Claims to: Exclusive Care Select
P.O. Box 1508
Riverside CA 92502-1508

Employer Name : **County of Orange**

Subscriber Name (Last, First MI)	Date of Birth / /	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Member ID#:
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Subscriber Home Address Street	City	State	Zip
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Spouses Name (Last, First MI)	Spouses Member ID:	Spouses Occupation:
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Name and Address of Spouses Employer

Patient Name (Last, First MI)	Patient's Date of Birth / /	Relationship to Subscriber
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Patient's Occupation:	Was condition related to patient's employment? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, has patient filed for Worker's Compensation Benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No
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Does the patient have other insurance coverage? Yes No
If yes, give the name and address of the carrier and the Policy number:

Carrier name	Carrier Address	Policy Number:
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Does the patient have Medicare? Yes No
If yes, Part A effective date: _____
Part B effective date: _____

Assignment of Benefits:

I authorize payment of benefit directly to the person or organization that provided care, not to exceed the benefits otherwise payable to me for the services rendered.

Patient or Legal Guardian Signature _____ **Date**

Authorization:

To all physicians and other medical professionals, hospitals and other medical care providers, institutions and to insurers, medical or hospital service and prepaid health plans, employers and group policy holders, contract holders or benefit plan administrators:

You are authorized to provide Exclusive Care, Its affiliates and carriers, and any agent, benefit plan administrator or independent claim administrator acting on behalf of Exclusive Care with information concerning medical care, advice, treatment or supplies provided the patient or deceased named above.

I also authorize my employer/group policy holder to provide Exclusive Care with information to be used to evaluate this claim for benefits. I understand the authorized representative may receive a copy of this authorization upon request. A copy of this authorization shall have the same authority as the original. This authorization will remain in effect for six (6) months from the date provided below or until terminated upon my request.

Patient or Legal Guardian Signature _____ **Date**

This form is to be used for services obtained through a provider who is not contracted directly with Exclusive Care or PHCS/MultiPlan network under the Exclusive Care Select Plans. Contracted providers should follow the regular billing procedures described in their contract.