



Point of Service

AmeriHealth

TYPE OR PRINT

REMEMBER TO AVOID DELAYS, BE SURE ITEM 9, EMPLOYEE'S SOCIAL SECURITY # IS PROVIDED

INFORMATION WE NEED FROM YOU

SECTION A

I am choosing to receive covered healthcare services for myself or a dependent outside of the designated referral system. I understand that by using non-referred providers, I will be subject to a deductible, coinsurance and other co-payments, as specified in the AmeriHealth contract.

SIGNED - EMPLOYEE OR SPOUSE X	DATE	THIS SECTION MUST BE SIGNED BEFORE A CLAIM MAY BE PROCESSED
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SECTION B

1. PATIENT'S NAME (FIRST, M.I., LAST)		ID #
2. PATIENT'S ADDRESS (IF DIFFERENT FROM EMPLOYEE)		
STREET		
CITY		STATE ZIP CODE
HOME TELEPHONE NO.		BUSINESS TELEPHONE NO.
3. PATIENT'S DATE OF BIRTH (MONTH/DAY/YEAR)	4. PATIENT'S SEX <input type="checkbox"/> M <input type="checkbox"/> F	5. PATIENT'S RELATION TO EMPLOYEE <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER
6. SUBSCRIBER'S NAME (FIRST, M.I., LAST)		ID #
7. SUBSCRIBER'S ADDRESS AND TELEPHONE NO.		
STREET		
CITY		STATE ZIP CODE
HOME TELEPHONE NO.		BUSINESS TELEPHONE NO.
8. WAS CONDITION RELATED TO:	A. PATIENT'S EMPLOYMENT <input type="checkbox"/> YES <input type="checkbox"/> NO	B. AN ACCIDENT <input type="checkbox"/> YES <input type="checkbox"/> NO
		IF AN ACCIDENT
		DATE
		TIME <input type="checkbox"/> AM <input type="checkbox"/> PM
9. SUBSCRIBER'S SOCIAL SECURITY NUMBER		10. GROUP NO.
		10a. GROUP NAME (EMPLOYER'S COMPANY NAME)
11. IS PATIENT COVERED BY ANY OTHER HEALTH PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO		NAME OF POLICY HOLDER
		NAME AND ADDRESS OF INSURANCE COMPANY
		POLICY NUMBER
12. IS PATIENT COVERED BY MEDICARE? <input type="checkbox"/> YES <input type="checkbox"/> NO	13. IS CHILD FULL-TIME STUDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	I authorize the release of any information necessary to process this request.
		14. SIGNED (PATIENT OR PARENT IF MINOR) X

INFORMATION TO BE COMPLETED BY PHYSICIAN

SECTION C

15. NAME AND ADDRESS OF FACILITY WHERE SERVICES RENDERED (IF OTHER THAN HOME OR OFFICE)		16. DATE FIRST CONSULTED YOU FOR THIS CONDITION					
17. DIAGNOSIS, OR NATURE OF ILLNESS OR INJURY. RELATE DIAGNOSIS TO PROCEDURE IN COLUMN BY REFERENCE TO #S 1,2,3 ETC. OR DX CODE							
18. A. PLACE OF SERVICE	B. DATE OF SERVICE	C. FULLY DESCRIBE PROCEDURE, MEDICAL SERVICES, OR SUPPLIES FOR EACH DATE				D. DIAGNOSIS CODE OR UNITS	E. CHARGES
		PROCEDURE CODE	MOD1	MOD2	EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES		
19. YOUR PATIENT'S ACCOUNT NO.		20. PHYSICIAN OR SUPPLIER'S NAME, ADDRESS, ZIP CODE AND TELEPHONE NUMBER				22. TOTAL CHARGES	
21. ENTER THE TAXPAYER ID NUMBER TO BE USED FOR 1099 REPORTING PURPOSES. YOU ARE REQUIRED BY LAW TO FURNISH YOUR TAXPAYER ID NUMBER.						23. AMOUNT PAID	
TAXPAYER ID NO.		25. SIGNATURE OF PHYSICIAN OR SUPPLIER				DATE	
						24. BALANCE DUE	

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any material false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties. PROVIDERS: By signing this document, you swear or affirm that the services or materials for which claim is being made were necessary and were, in fact, furnished.

EMPLOYEE

1. EACH TIME YOU REQUEST BENEFITS SIGN SECTION A AND COMPLETE SECTION B (ITEMS 1 THROUGH 14) ON THE REVERSE SIDE OF THIS FORM.

USE A SEPARATE BENEFIT REQUEST FORM FOR EACH MEMBER OF THE FAMILY.

2. ASK YOUR DOCTOR, HOSPITAL OR SUPPLIER TO COMPLETE (SECTION C THE PHYSICIAN OR SUPPLIER INFORMATION ITEMS 15 - 25) OR ATTACH ITEMIZED BILLS.

ITEMIZED BILLS SHOULD INCLUDE:

DOCTOR'S NAME & ADDRESS

PATIENT'S NAME

DATE OF SERVICE

CONDITION BEING TREATED/DIAGNOSIS

CHARGE FOR SERVICE

TYPE OF SERVICE

SEND THIS REQUEST FOR BENEFITS TO:
AMERIHEALTH PROCESSING SERVICES
PO BOX 41574
PHILADELPHIA, PA 19010-1574

IF YOU HAVE ANY QUESTIONS, CALL:
1-800-422-2457

DOCTOR, HOSPITAL OR SUPPLIER

1. COMPLETE ITEMS 15 THROUGH 25 ON THE BENEFITS REQUEST FORM USING CURRENT CPT PROCEDURE AND ICD-CM DIAGNOSIS CODES.

2-DIGIT PLACE OF SERVICE CODES

(THE CURRENT 2-DIGIT PLACE OF SERVICE CODE MUST BE USED ON ALL CLAIMS SUBMISSIONS)

11	OFFICE	51	INPATIENT PSYCHIATRIC FACILITY
12	HOME	52	PSYCHIATRIC FACILITY PARTIAL HOSPITALIZATION
21	INPATIENT HOSPITAL	53	COMMUNITY MENTAL HEALTH CENTER
22	OUTPATIENT HOSPITAL	54	INTERMEDIATE CARE FACILITY/MENTALLY RETARDED
23	EMERGENCY ROOM (HOSPITAL)	55	RESIDENTIAL SUBSTANCE ABUSE TREATMENT FACILITY
24	AMBULATORY SURGICAL CENTER (ASC)	56	PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY
25	BIRTHING CENTER	61	COMPREHENSIVE INPATIENT REHAB FACILITY
26	MILITARY TREATMENT FACILITY	62	COMPREHENSIVE OUTPATIENT REHAB FACILITY
31	SKILLED NURSING FACILITY (SNF)	65	END STAGE RENAL DISEASE TREATMENT CENTER
32	NURSING FACILITY	71	STATE OR LOCAL PUBLIC HEALTH CENTER
33	CUSTODIAL CARE FACILITY	72	RURAL HEALTH CLINIC
34	HOSPICE	81	INDEPENDENT LABORATORY
41	AMBULANCE (LAND)	99	OTHER UNLISTED FACILITY
42	AMBULANCE (AIR OR WATER)		