



Claim Form

USE SEPARATE FORM FOR EACH PATIENT

SUBMIT TO

P.O. Box 1787, Columbus, IN 47202-1787
Call Local: (812) 378-7070 or Toll Free in Indiana 1-800-443-2980

ACCOUNT NO. (FROM SIHO I.D. CARD)

MEMBER IDENTIFICATION NO. (FROM SIHO CARD)

PATIENT INFORMATION

PATIENT NAME (Print) _____ SEX M F BIRTHDATE _____
RELATIONSHIP TO EMPLOYEE SELF CHILD SPOUSE OTHER _____

EMPLOYEE INFORMATION

EMPLOYEE NAME _____ Check if new address
EMPLOYEE ADDRESS _____ City _____ State _____ Zip _____

OTHER INSURANCE INFORMATION

IS PATIENT COVERED BY ANOTHER MEDICAL PLAN? YES NO
IF YES, INDICATE MEDICAL PLAN NAME _____ POLICY NUMBER _____
IDENTIFICATION NUMBER _____ EFFECTIVE DATE OF COVERAGE _____
NAME, ADDRESS AND PHONE # OF OTHER CARRIER _____
EMPLOYER'S NAME _____ Phone _____ EMPLOYEE BIRTH DATE _____
Mo. Day Year
SPOUSE'S BIRTH DATE _____
Mo. Day Year

IF YOU ARE ELIGIBLE FOR MEDICARE:

- Submit bills for all charges except prescription drugs to Medicare first. Make sure you keep a copy of the itemized bill, since you will also need to submit it to SIHO.
- You will receive the Explanation of Benefits Statement from Medicare, indicating payment or denial of your claim submission. Submit the Medicare statement and a copy of itemized bill to SIHO.
- Some physicians and other medical providers will file your Medicare claims directly for you. You need to tell them to send you a copy of the itemized bill also, since you need to send it to SIHO once you receive Medicare's Explanation of Benefits.

ACCIDENT INFORMATION

Were the medical services received as a result of an accident YES NO Date of Injury: _____
If Yes, was the accident: at home in a vehicle Approximate time: _____
 at work – has a first aid report been submitted to supervision? YES NO Description of accident and injuries: _____
 other – where? _____
Is there a possible recovery of medical expenses from a third party? YES NO

PATIENT AUTHORIZATION AUTHORIZATION FOR USE IN CLAIMING GROUP BENEFITS

To all physicians and other medical professionals, hospitals and other medical care institutions, and to insurers, medical or hospital service and prepaid health plans, employers and group policyholders, contractholders or benefit administrators:

You are authorized to provide any benefit plan administrators, consumer reporting agencies, attorneys and independent claim administrators acting on SIHO's behalf, with information regarding the Patient. This information will be used for the purpose of evaluating and administering claims for benefits.

I hereby authorize SIHO to provide the information relating to medical services and treatment rendered to me and/or my dependents. I understand that the duration of the authorization is for the term of coverage of the policy or contract under which a claim for health benefits has been submitted. I understand that I have a right to receive a copy of this authorization upon request. I agree that a photographic copy of this authorization is as valid as the original.

I have furnished the information on this form so that SIHO may consider this claim. By signing below, I certify the information is correct and the expenses were incurred by the patient named above.

Should there be an overpayment in excess of the amount payable under the Medical Plan, I agree to reimburse SIHO to the extent of the overpayment.

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE _____ RELATIONSHIP OF AUTHORIZED PERSON _____ DATE _____

PAYMENT AUTHORIZATION

PAY TO PROVIDER
 I authorize benefits to be paid directly to the physician or other provider of service.

PAY TO ME
 I authorize benefits to be paid to me. I understand it is my responsibility to pay the physician, hospital, or other provider of service.

EMPLOYEE / RETIREE / SURVIVOR SIGNATURE _____ DATE _____

EMPLOYEE / RETIREE / SURVIVOR SIGNATURE _____ DATE _____