HEALTHCARE MANAGEMENT ADMINISTRATORS

MEDICAL CLAIM FORM

Please return this form to Healthcare Management Administrators (HMA) by mail or fax:

Mail: HMA
Attn: Claims Department
PO Box 85008
Bellevue WA 98015

Fax: 1-866-458-5488

SECTION 1 – EMPLOYEE INFORMATION		
Employee Name:		Member ID Number:
Address:		Is this an address change: ☐ Yes ☐ No
Phone Number: ( )	Employee's Date of Birth:	Group Name and Group Number:
Marital Status: ☐ Single ☐ Widowed ☐ Legally Separated ☐ Divorced ☐ Married If married, provide name of spouse:		
If you are divorced and the claim(s) are for a dependent child or children, please answer these questions: Is this child (or children) in your permanent custody? ☐ Yes ☐ No Is there a court order for provision of medical care for this child (or children)? ☐ Yes ☐ No		

SECTION 2 – PATIENT INFORMATION	
Patient Name:	Patient is: ☐ Employee ☐ Spouse ☐ Child ☐ Other If other, specify:
Address:	
Phone Number: ( )	Patient's Date of Birth:
If claim(s) are for a dependent over age 19, is the dependent a full-time student? ☐ Yes ☐ No If yes, attach proof of student status and identify it here:	

SECTION 3 – DESCRIPTION OF CLAIM
Description of Illness or Injury:
Is this a work-related illness or injury? ☐ Yes ☐ No If yes, did you file or will you be filing a claim with Labor & Industries (L&I)? ☐ Yes ☐ No
If claim is due to an accident, state when, where, and how the accident occurred:

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SECTION 4 – OTHER GROUP HEALTH INSURANCE

Are you or any of your family members covered by other insurance for medical, dental, or vision benefits?
☐ Yes ☐ No

Check only those covered by other group insurance: ☐ Self ☐ Spouse ☐ Dependent(s)

If spouse, provide date of birth: _____

If dependent(s), list name(s): _____

Name and address of other insurance carrier:

Phone number of other insurance carrier:	Policy Number:	Effective Date:

Is patient eligible for Medicare benefits? ☐ Yes ☐ No

If yes, enter date of eligibility:	Patient's Social Security Number:

SECTION 5 – CERTIFICATION

Caution: Any person who knowingly and with intent to defraud any insurance company, benefits administrator, or other entity: (1) files an application for insurance or statement of claim containing any materially false information; or (2) conceals information concerning any material fact for the purpose of misleading, commits a fraudulent insurance act.

I certify that the information I provided on this form is true and complete.

_____ _____
(Signature) (Date)

SECTION 6 – CLAIMS BENEFIT ASSIGNMENT

Sign here if you want to receive payment; otherwise, payment will be given to the provider of care.

_____ _____
(Signature) (Date)

SECTION 7 – AUTHORIZATION TO RELEASE INFORMATION

I expressly authorize any provider of care to provide Healthcare Management Administrators with any records concerning me or any member of my family for whom benefits or services have been claimed.

_____ _____
(Signature) (Date)