MEDICAL CLAIM FORM

Trustmark Health Benefits
P.O. Box 2920
Clinton, IA 52733-2920
(913) 685-4740 (800) 990-9058 (913) 681-0886 Fax

Instructions:
1. Please complete all sections
2. All itemized bills MUST be attached and include: Patient's name, Provider's name, diagnosis, dates of services and charge amount.
3. If you or a dependent are covered by another Plan (including Medicare), please submit the bill to the Primary Plan first. Then send our office a copy of the Explanation of Benefits along with the bill.

EMPLOYEE INFORMATION

Name (First, MI, Last)	Sex ☐ Male ☐ Female	Birthdate	Member Number
Home Address / City / State / Zip			
Employer:	Date of Hire	Occupation	Date Last Worked

PATIENT INFORMATION

Patient Name (First, Middle, Last)	Relationship	Sex ☐ Male ☐ Female	Birthdate

Is the Patient Married? ☐ Yes ☐ No	Is the Patient a Full-time Student? ☐ Yes ☐ No	If yes, How Many Hours?	Date Last Attended?	Name and Address of School
Nature of Illness	Name, Address and Phone No. of Doctor Seen For This Illness			

IF CLAIM IS BASED ON AN ACCIDENT, COMPLETE THE FOLLOWING

Date and Time of Accident	Was Accident Work Related? ☐ Yes ☐ No	Place	How It Happened

SPOUSE INFORMATION

Name (First, MI, Last)	Sex ☐ Male ☐ Female	Birthdate	Soc. Sec. No.
Spouse's Employer Name / Address / Phone No.			

OTHER INSURANCE INFORMATION

Do You or Your Dependents Have Other Coverage? ☐ Yes ☐ No	Type of Coverage? ☐ Single ☐ Family	Type of Plan? ☐ Group Health Plan ☐ Government Plan ☐ Medicare ☐ Other

Name of Person Covered by Other Insurance	Group Number	Soc. Sec. No.	Benefits ☐ Medical ☐ Dental ☐ Vision ☐ Other
Name and Address and Phone No. of Other Insurance Company			

INFORMATION ABOUT YOUR OTC COVID-19 TEST

To be eligible for reimbursement, you must submit:

- A separate claim form for each member for whom the at-home test is purchased on or after Jan. 15, 2022.
- Proof Of Payment such as the Original receipt(s) for at-home test(s), showing the amount paid and the test(s) purchased.
- The UPC/barcode information from the at-home test(s)

If we don't receive the required information, your request will not be processed.

Name of the FDA authorized test(s) purchased (e.g., BinaxNOW, QuickVue, Intelliswab, etc.)	Purchase date(s)
Please attach proof of purchase/receipt	How many tests are you submitting for reimbursement? (some kits include more than one test – enter the total number of tests)

ATTESTATION:
I attest that the over the counter COVID-19 test(s) I am submitting for reimbursement will not be used for employment testing purposes, nor sold for profit. When I sign below, I am stating that the information above is correct. Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete, or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

MEMBER SIGNATURE _____ DATE _____

AUTHORIZATION TO RELEASE INFORMATION --
I hereby authorize any Dentist, Physician, Hospital, Insurance Company, Organization, or Employer to release any information to Trustmark Health Benefits for any oral or dental observation, treatment, services, or benefits rendered or payable to me or on my behalf. A photocopy of this authorization shall be valid as the original

PATIENT'S SIGNATURE (PARENT IF MINOR) _____ DATE _____

AUTHORIZATION TO PAY BENEFITS TO PROVIDERS --
I hereby authorize payment of benefits to any providers of service rendered or payable to me or on my behalf. A photocopy of this authorization shall be valid as the original

PATIENT'S SIGNATURE (PARENT IF MINOR) _____ DATE _____