CENTIVO®

Medical Claim Form

Instructions for completing this form

- Complete items one (1) through nineteen (19) in full.
- Complete items twenty (20) through twenty-seven (27) only if other medical coverage exists.
- Be certain to sign the authorization to release information in block twenty-eight (28).
- If you wish to have your benefits for this claim paid directly to your physician or supplier, sign block twenty-nine (29).
- Attach itemized bills. The bills must include:
  - Patient's name
  - Date(s) of service
  - CPT code(s) (this tells us the services/procedures that you or your family received, e.g., 99213)
  - ICD-10 code(s) (these are diagnosis codes, such as G44.311)
  - Provider's Tax ID Number
  - Provider's NPI or National Provider Identifier
  - Itemized charges billed for each service
- If you wish to have your benefits for this claim paid directly to you, attach proof of payment. (Note: this may or may not be included on the itemized bill.)
- If you have submitted a request for benefits to another plan, including Medicare, attach a copy of the bills you submitted to the other plan and the explanation of benefits you received from the other plan.

The completed form and all required attachments can be emailed to MemberSupport@centivo.com (use the subject line "Member Claims"), faxed to 716-219-1946, or mailed to:

Centivo
Attention: Member Claims
307 Cayuga Road, Suite 170
Buffalo, NY 14225

If you have any questions, please contact the Centivo support team using the number listed on the back of your Centivo member ID card. Be sure to keep a copy of this claim form and any receipts for your records.

To be completed by employee

1. Employer's name:		
2. Group ID (found on ID card):	3. Employee's member ID (found on ID card):	
4. Employee's last name:	First name:	M.I.:
5. Employee's birth date (MM/DD/YYYY):	6. Employee's daytime phone number:	

Questions continue on next page »

7. Employment status: ○ Active ○ Retired		Retirement date (MM/DD/YYYY):	
8. Employee's street address:	City:	State:	Zip:
9. Patient's name:		10. Patient's member ID (found on ID card):	
11. Patient's birth date (MM/DD/YYYY):		12. Patient's relationship to employee: ○ Self ○ Spouse ○ Child ○ Other	
13. Patient's street address:	City:	State:	Zip:

14. Patient's gender: ○ M ○ F ○ Other	15. Patient's marital status: ○ Married ○ Single	16. Patient employed? ○ Yes ○ No	17. Claim related to employment? ○ Yes ○ No

18. Patient's employer name (if applicable):			
Employer street address:	City:	State:	Zip:
19. Is claim related to an accident? ○ Yes ○ No	If YES, date (MM/DD/YYYY):	Time:	○ AM ○ PM

20. Are any expenses for employee's family members covered by another group health plan, group pre-payment plan (for example, Aetna or Cigna), no fault auto insurance, Medicare or any federal, state or local government plan? (If YES, complete fields 21–27)
○ Yes ○ No

21. Policy or contract holder name:	22. Policy or contract number(s):
23. Insurance company or administrator name:	

24. Insurance co. or admin. street address:	City:	State:	Zip:
25. Member's last name:	First name:		
26. Member's ID (found on ID card):	27. Member's birth date (MM/DD/YYYY):		

28. **Authorization to release healthcare information:**

I am authorizing my healthcare provider(s) to supply Centivo with information concerning healthcare advice, treatment or supplies provided to me (including that relating to mental illness and/or AIDS/ARC/HIV). This information will be used to evaluate claims for benefits. Centivo may provide the employer named above with any benefit calculation used in payment of this claim for the purpose of reviewing the experience and operation of the policy or contract. This authorization is valid for the term of the contract under which a claim has been submitted. I know that I have a right to receive a copy of this authorization upon request and agree that a photographic copy of this authorization is as valid as the original.

Patient or authorized representative name:	Patient or authorized representative signature:	Date:

29. (Optional) I authorize payment of medical benefits to the physician or supplier of service.

Patient or authorized representative name:	Patient or authorized representative signature:	Date: