Member Claim Form

Complete the claim form for each member submitting bills for reimbursement of covered services. To avoid any delay, be sure to answer each question completely. **Please attach fully itemized bills and proof of payment**, or ask your physician to complete the back of this form.

Submit to: California Health & Wellness
Attention: Member Services
1740 Creekside Oaks Drive, Suite 200
Sacramento, CA 95833

CHW USE ONLY
Member Number#

Member information – *Member # must be indicated to assure prompt processing of this request.*					
Last name:	First name:	MI:	Medi-Cal #:		
Residence address:	City:	State:	ZIP:		
Date of birth (Mo / Day / Yr):	Phone #:	Email address:	Marital Status: ☐ Married ☐ Single ☐ Domestic partner		
Did you obtain services from a California Health & Wellness network physician? ☐ Yes ☐ No					
Have you or your physician received precertification for all or part of the claim? ☐ Yes ☐ No Approx. date:					

Illness / Injury / Pregnancy information		
Name of referring physician:	Is the injury or illness work related? ☐ Yes ☐ No If "Yes," employer's name: Is the injury or illness due to third-party liability? ☐ Yes ☐ No	Date accident or illness occurred:

Other health insurance information			
Is patient presently covered by other medical insurance, including Medicare? ☐ Yes ☐ No		For Medicare, indicate parts member is enrolled in: ☐ Part A ☐ Part B ☐ Part D	
Name of other insurance company:	Policy #:	Effective date:	Member ID #:
Insurance company address:	City:	State:	ZIP:
Name of insured policy holder:	Social Security #:		Date of birth:
Employer name:	Employer address:	City:	State: ZIP: Phone #:

Authorization to obtain and release medical information

I hereby authorize any physician, health care practitioner, hospital, clinic, or other medically related facility to furnish to California Health & Wellness, its agents, designees, or representatives, any and all information pertaining to medical treatment for purposes of reviewing, investigating or evaluating applications or claims. I also authorize California Health & Wellness, its agents, designees, or representatives to disclose to a hospital or health care service plan, insurer or self-insurer any such medical information obtained if such disclosure is necessary to allow the processing of any claim. This authorization shall become effective immediately and shall remain in effect as long as California Health & Wellness is asked to process claims under my coverage. A photostatic copy of this authorization shall be considered as effective and valid as the original. I hereby certify that the above statements are correct.

Signature of Member: **X**	Name of person preparing form (please print):	Phone #:

(continued)

Step 2. Physician statement:
If you don't have an itemized bill and proof of payment, please have your physician or supplier complete the following sections, making sure all information is addressed.

Patient Information *(to be completed by patient)*		
Last name:	First name:	MI:
Release of medical information I authorize the release of any medical information necessary to process this claim. Signature of insured or authorized person: Date: (parent or guardian if patient is a minor) X	*Assignment of medical benefits* I authorize payment of medical benefits to the undersigned physician or supplier for services described below. Signature of insured or authorized person: Date: X	

Physician or supplier information *(to be completed by Physician or Supplier)*		
Date of illness (first symptoms) or injury (accident):	Date you were first consulted for this condition:	Has patient ever had same or similar symptoms? ☐ Yes ☐ No If "Yes," date(s):
Date patient is able to return to work:	Dates of total disability: From: Through:	Dates of partial disability From: Through:
Name of referring physician:		Hospitalization dates for related services: Admitted: Discharged:
Name and address of facility where services rendered (if other than home or office):		Laboratory work outside your office: ☐ None ☐ Yes Charges:

Diagnosis or nature of illness or injury – Relate diagnosis to procedure in column D by reference to number 1, 2, 3, or 4 or DX code. Please give CPT procedure code in C and ICD in D below.

1.
2.
3.
4.

A Dates of Service	B[1] Place of Service	C - Procedures, medical services or supplies furnished Procedure Code (Identify)	 Description (explain unusual services or circumstances)	D Diagnosis Code	E Charges	F (internal use)

[1]Place of Service Codes

11 Doctor office	23 Emergency room	55 Residential substance abuse treatment facility
12 Patient home	24 Ambulatory surgery center	
20 Urgent care facility	31 Skilled nursing facility	81 Independent laboratory
21 Inpatient hospital	41 Ambulance	99 Other place of service
22 Outpatient hospital		

Total Charge:

Amount Paid:

Balance Due:

Signature of physician or supplier: X	Accept assignment? ☐ Yes ☐ No (If "Yes," Tax ID # must be given below)	Physician or supplier name, address, ZIP code, and telephone #:
Date:	Physician Social Security #:	
Member ID #:	Physician Tax ID #:	License #:

For your protection, California law requires the following statements to appear on this form.
Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.