



SUBMIT ALL CLAIMS TO: CA.claims@lucenthealth.com

IMPORTANT INSTRUCTIONS

- USE A SEPARATE CLAIM FORM FOR EACH MEMBER OF THE FAMILY AND FOR EACH DIFFERENT PROVIDER OF SERVICE (DOCTOR, DENTIST, LAB, ETC.)
- TYPE OR PRINT ALL INFORMATION
- FILL IN ALL ITEMS COMPLETELY (WHERE APPLICABLE)
- SIGN AND DATE THE FORM IN THE SPACES PROVIDED
- IF CAPITOL IS YOUR SECONDARY INSURANCE, ATTACH A COPY OF THE EXPLANATION OF BENEFITS (EOB) FROM YOUR PRIMARY CARRIER
- ATTACH THE ORIGINAL ITEMIZED BILL(S) FOR THE SERVICES OF THIS PROVIDER (WE CANNOT ACCEPT 'BALANCE STATEMENTS', CASH REGISTER OR CREDIT CARD RECEIPT(S))

EMPLOYER'S NAME					
NAME OF EMPLOYEE			DATE OF BIRTH (Month, day, year)	SEX	
HOME ADDRESS		STREET OR P.O. BOX NUMBER		CITY	STATE
EMPLOYEE'S SOCIAL SECURITY NO.		OCCUPATION		<input type="checkbox"/> MARRIED <input type="checkbox"/> SINGLE	<input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED
NAME OF SPOUSE		DATE OF BIRTH (Month, day, year)	IS YOUR SPOUSE EMPLOYED? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES, NAME AND ADDRESS OF EMPLOYER	
IS THE PATIENT, OR ANY FAMILY MEMBER ENROLLED IN AN HMO, PPO OR COVERED UNDER ANY MEDICAL, DENTAL OR OTHER GROUP INSURANCE PLAN			<input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES, GIVE NAME AND ADDRESS OF HMO, PPO FACILITY, EMPLOYER OR OTHER GROUP INSURANCE CO.	
DEPENDENT INFORMATION					
IS CLAIM FOR DEPENDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		NAME OF DEPENDENT, IF OTHER THAN SPOUSE			DEPENDENT'S RELATIONSHIP TO EMPLOYEE
DEPENDENT'S DATE OF BIRTH (Month, day, year)		IF DEPENDENT IS A FULL-TIME STUDENT, GIVE NAME AND ADDRESS OF SCHOOL			
PATIENT & INSURED (SUBSCRIBER) INFORMATION					
1. PATIENT'S NAME (First name, middle initial, last name)		2. PATIENT'S DATE OF BIRTH		3. INSURED'S NAME (First name, middle initial, last name)E	
4. PATIENT'S ADDRESS (Street, City, State, Zip code)		5. PATIENT'S SEX <input type="checkbox"/> M <input type="checkbox"/> F		6. INSURED'S I.D., MEDICARE AND OR MEDICAID NO. (Include any letters)	
		7. PATIENT'S RELATIONSHIP TO INSURED		INSURED'S GROUP NO. (or Group Name)	
9. OTHER HEALTH INSURANCE COVERAGE – Enter Name of Policyholder, Plan Name, address and policy number		10. WAS CONDITION RELATED TO: <input type="checkbox"/> PATIENT'S EMPLOYMENT <input type="checkbox"/> AN AUTO ACCIDENT		11. INSURED'S ADDRESS (Street, City, State, Zip Code)	
12 - 13 I certify the above is complete and correct and I am claiming benefits only for charges by the patient named above. Authorization is hereby given to any hospital, physician, or other provider which participated in any way with the care and treatment, or insurance company prepaid health plan, employer or group policyholder, contract holder or benefit plan administrator to release to the above Plan Administrator any medical information and any employment information regarding the patient, which they in their judgment deem necessary to evaluate and administer claim benefits. This authorization is valid for the duration of the claim. I know I have a right to receive a copy of this authorization and that its photographic copy is as valid as the original.					
SIGNATURE (Insured or Authorized Person)				DATE	

