CORESOURCE

A Trustmark Company
Core Source, Inc.
P.O. Box 6118
Westerville, OH 43086-6118

MERCER-AUGLAIZE EMPLOYEE BENEFIT TRUST

Submit all Medical Claims to:
MMOH
PO Box 94648
Cleveland, OH 44101-4648

PLEASE SUBMIT ITEMIZED BILLS AND ONE CLAIM FORM FOR EACH FAMILY MEMBER.
PLEASE ANSWER ALL QUESTIONS AND KEEP COPIES OF THE BILLS YOU SUBMIT.
IF YOU HAVE SUBMITTED THIS CLAIM TO ANOTHER HEALTH PLAN, PLEASE ATTACH A COPY OF THEIR RESPONSE.

About The Employee

Name ______________________ Soc. Sec. # ___ - __ - ____

Mailing Address ______________________ Telephone ______________

City/State/Zip ______________________ Date of Birth ____/____/____

Name of Employer ______________________

Employee Status ☐ Active ☐ Retired ☐ Leave of Absence ☐ COBRA

About The Spouse

Name of Spouse ______________________ Soc. Sec. # ___ - __ - ____

Date of Birth ____/____/____ Name of Spouse's Employer ______________________

Address of Spouse's Employer ______________________

Phone Number of Spouse's Employer (____) ______________

About Other Health Insurance

Is Spouse Covered By Any Other Health Plan? ☐ Yes ☐ No

Is The Patient Covered By Any Other Health Plan? ☐ Yes ☐ No

Name, Address, and Telephone of Other Health Plan	*Name of Insured and Policy Number*	*Name and Address of Employer*

About The Patient

This Claim Is For

☐ Male ☐ Female
☐ Employee ☐ Spouse
☐ Dependent–Name ______________________ Date of Birth ____/____/____
Relationship ______________________
Is This Child an IRS Dependent? ☐ Yes ☐ No
If Over 19 Years of Age, Is Child a Full Time Student? ☐ Yes ☐ No
School Name ______________________ Graduation Date ____/____/____
Please provide class schedule each semester.

About The Claim

If Claim Was Due To:

1. Is this condition related to employment? ☐ Yes ☐ No

2A. An Accident
Nature of Injury ______________________
How Did It Happen?
____
Where? ______________________ When? ____/____/____

Or:

2B. An Illness
Nature of Illness ______________________
When Did Symptoms Begin ____/____/____
When Was A Physician First Consulted? ____/____/____

A. AUTHORIZATION TO RELEASE INFORMATION. I authorize any Health Care Provider, Insurance Company, Employer, Person or Organization to release any information regarding the medical, dental, mental, alcohol or drug abuse history, treatment, or benefits payable, including disability or employment related information, to CoreSource, Inc., the Plan Administrator, or their authorized agents for the purpose of validating and determining benefits payable. I will receive a copy of this authorization upon request. This authorization or a copy shall be valid until revoked in writing.

Patient's Signature (Parent or Guardian if Claim is on a Minor) ______________________ Date __________

PAYMENT AUTHORIZATION ON REVERSE SIDE

HEALTH PLAN CLAIM FORM

READ INSTRUCTIONS BEFORE COMPLETING OR SIGNING THIS FORM.

Any previous claims for this family?	Yes ☐ When?	No ☐	(Date)	Has Employee made claim for Worker's Compensation? Is Employee entitled to such benefits?	Yes ☐ Yes ☐	No ☐ No ☐

PATIENT INFORMATION

PATIENT'S NAME (First name, middle initial, last name)

NOTE: If you wish your benefits paid directly to the physician or provider of service, sign in box B, below. Benefits will be paid directly to the hospital for a hospital confinement.

B. PAYMENT AUTHORIZATION. I authorize payment directly to those Health Care Providers described below, and/or as indicated on the enclosed bills, of Medical Benefits otherwise payable to me, for services rendered by them.	IF YES, EMPLOYEE'S SIGNATURE	DATE
C. CERTIFICATION. I certify that this information is true and correct. **FRAUD WARNING:** Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.	EMPLOYEE'S SIGNATURE	DATE

PHYSICIAN OR SUPPLIER INFORMATION

1. Date of	Illness (First symptom) or Injury (Accident) or Pregnancy (LMP)	2. Date first consulted you for this condition	3. Has patient ever had same or similar symptoms? Yes ☐ ☐ No
4. Date Patient Able to return to work	5. Dates of Total Disability From	Through	Dates of Partial Disability From / Through
6. Name of Referring Physician			7. For services related to hospitalization. Give Hospitalization dates Admitted / Discharged
8. Name and address of facility where services rendered (if other than home or office)			9. Was laboratory work performed outside your office:? Yes ☐ ☐ No Charges
10. Diagnosis or Nature of Illness or Injury 1 2 3 4			WAS CONDITION RELATED TO PATIENT'S EMPLOYMENT? YES ☐ NO ☐ HAVE YOU CERTIFIED A HOME HEALTH CARE TREATMENT PLAN FOR THIS PATIENT? YES ☐ NO ☐

Relate Diagnosis to Procedure in Column D by Reference to Numbers 1, 2, 3, etc. or DX Code

11. A Date of Service	B* Place of Service	C. Fully Describe Procedures Medical Services or Supplies Furnished For Each Date Given Procedure Code (Identify)	*(Explain Unusual Services or Circumstances)*	D Diagnosis Code	E Charges		F

IS THE ATTACHED BILL FOR A SECOND OPINION? YES ☐ NO ☐

12. Signature of Physician or Supplier Signed / Date	13. Accept Assignment Yes ☐ ☐ No	14. Total Charge	15. Amt. Pd.	16. Bal. Due
	17. Your Social Security No.	18. Physician's or Supplier Name, Address, Zip Code & Telephone No.		
19. Your Patient's Account No.	20. Your Employer I.D. No.	I.D. No.		

*PLACE OF SERVICE CODES

PAYMENT WILL BE MADE TO COVERED PERSON IF NO I.D. IS PROVIDED.

1–(IH)–Inpatient Hospital	4–(H)–Patient's Home	7–(NH)–Nursing Home	O–(OL)–Other Locations
2–(OH)–Outpatient Hospital	5– Day Care Facility (Psy)	8–(SNF)–Skilled Nursing Facility	A–(IL)–Independent Laboratory
3–(O)–Doctor's Office	6– Night Care Facility (Psy)	9– Ambulance	B– Other Medical/Surgical Facility