SIHO INSURANCE SERVICES

SUBMIT TO
P.O. Box 1787, Columbus, IN 47202-1787
Call Local: (812) 378-7070 or Toll Free in Indiana 1-800-443-2980

Deaconess Health System

Claim Form

USE SEPARATE FORM FOR EACH PATIENT

_____
ACCOUNT NO. (FROM SIHO I.D. CARD)

_____
MEMBER IDENTIFICATION NO. (FROM SIHO CARD)

PATIENT INFORMATION

PATIENT NAME (Print) _____ SEX ❑ M ❑ F BIRTHDATE _____

RELATIONSHIP TO EMPLOYEE ❑ SELF ❑ CHILD ❑ SPOUSE ❑ OTHER _____

EMPLOYEE INFORMATION

EMPLOYEE NAME _____ Check if new address ❑

EMPLOYEE ADDRESS _____
City State Zip

OTHER INSURANCE INFORMATION

IS PATIENT COVERED BY ANOTHER MEDICAL PLAN? ❑ YES ❑ NO

IF YES, INDICATE MEDICAL PLAN NAME _____ POLICY NUMBER _____

IDENTIFICATION NUMBER _____ EFFECTIVE DATE OF COVERAGE _____

NAME, ADDRESS AND PHONE # OF OTHER CARRIER _____

EMPLOYER'S NAME _____ Phone _____ EMPLOYEE BIRTH DATE _____
Mo. Day Year

SPOUSE'S BIRTH DATE _____
Mo. Day Year

IF YOU ARE ELIGIBLE FOR MEDICARE:

- Submit bills for all charges except prescription drugs to Medicare first. Make sure you keep a copy of the itemized bill, since you will also need to submit it to SIHO.
- You will receive the Explanation of Benefits Statement from Medicare, indicating payment or denial of your claim submission. Submit the Medicare statement and a copy of itemized bill to SIHO.
- Some physicians and other medical providers will file your Medicare claims directly for you. You need to tell them to send you a copy of the itemized bill also, since you need to send it to SIHO once you receive Medicare's Explanation of Benefits.

ACCIDENT INFORMATION

Were the medical services received as a result of an accident ❑ YES ❑ NO

Date of Injury: _____

If Yes, was the accident: ❑ at home ❑ in a vehicle

Approximate time: _____

❑ at work – has a first aid report been submitted to supervision? ❑ YES ❑ NO

Description of accident and injuries: _____

❑ other – where? _____

Is there a possible recovery of medical expenses from a third party? ❑ YES ❑ NO

PATIENT AUTHORIZATION AUTHORIZATION FOR USE IN CLAIMING GROUP BENEFITS

To all physicians and other medical professionals, hospitals and other medical care institutions, and to insurers, medical or hospital service and prepaid health plans, employers and group policyholders, contractholders or benefit administrators:

You are authorized to provide any benefit plan administrators, consumer reporting agencies, attorneys and independent claim administrators acting on SIHO's behalf, with information regarding the Patient. This information will be used for the purpose of evaluating and administering claims for benefits.

I hereby authorize SIHO to provide the information relating to medical services and treatment rendered to me and/or my dependents.

I understand that the duration of the authorization is for the term of coverage of the policy or contract under which a claim for health benefits has been submitted. I understand that I have a right to receive a copy of this authorization upon request. I agree that a photographic copy of this authorization is as valid as the original.

I have furnished the information on this form so that SIHO may consider this claim. By signing below, I certify the information is correct and the expenses were incurred by the patient named above.

Should there be an overpayment in excess of the amount payable under the Medical Plan, I agree to reimburse SIHO to the extent of the overpayment.

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE | RELATIONSHIP OF AUTHORIZED PERSON | DATE

PAYMENT AUTHORIZATION

PAY TO PROVIDER

❑ I authorize benefits to be paid directly to the physician or other provider of service.

EMPLOYEE / RETIREE / SURVIVOR SIGNATURE DATE

PAY TO ME

❑ I authorize benefits to be paid to me. I understand it is my responsibility to pay the physician, hospital, or other provider of service.

EMPLOYEE / RETIREE / SURVIVOR SIGNATURE DATE