MAIL TO:
P.O. Box 331429
Corpus Christi, TX 78463

evergreen HEALTH

Medical Claim Form

THIS SIDE OF THE FORM MUST BE COMPLETED IN FULL. Attach this form to itemized bills for all expenses being claimed. The bills must show: Patient's Name, Type of Service by CPT/HCPCS/REV, ICD, Date(s) of Service(s), and the Total Charge. **AVOID DELAY-ANSWER ALL QUESTIONS.**

1 MEMBER INFORMATION

Member Legal Name (Last, First, Midlle Intital)	Member's Date of Birth	MONTH	DAY	YEAR
Member ID Number	Sex of Member ☐ Male ☐ Female	Member Relationship to Subscriber ☐ Self ☐ Spouse ☐ Child		
Street Address				
City	State	Zip Code		
Telephone Number	Cell Number	Email		

2 DEPENDENT INFORMATION

Dependent Legal Name (Last, First, Midlle Intital)	Dependent's Date of Birth	MONTH	DAY	YEAR
Dependent Relationship to Subscriber ☐ Spouse ☐ Child ☐ Other (Explain: _____)	Sex of Dependent ☐ Male ☐ Female			

3 COMPLETE FOR ALL PATIENTS

Diagnosis or nature of injury	When were you first treated for this condition?	MONTH	DAY	YEAR
Name of physician who first treated you				
Address of physician who first treated you				

Is patient also covered for benefits by:

- Other insurance of any kind including a commerical plan or Medicare? ☐ Yes ☐ No

If you answered YES please indicate:

Insurance company name and address: _____

Policy number: _____

Effective date of policy: _____

Was illness or injury due in any way to:

- The patient's occupation? ☐ Yes ☐ No
- An automobile accident? ☐ Yes ☐ No
- Any other type of accident? ☐ Yes ☐ No

If any of the above are answered YES please give details in the two rows below and the name of your attorney if applicable.

Name of attorney: _____

Attorney address: _____

Attorney phone: _____

Date of Accident	MONTH	DAY	YEAR	TIME ☐ a.m. ☐ p.m.	PLACE OF ACCIDENT ☐ Work ☐ Other (Explain: _____)
How did the accident happen?					Name and address where accident occurred

		MONTH	DAY	YEAR
Authorization to pay benefits to physician: I hereby authorize payment of medical benefits to physician or supplier for services described within	Signed (Patient, or Parent if minor)			
Authorization to release information: I hereby authorize the release of any medical information necessary to process this claim.	Signed (Patient, or Parent if minor)			

MEMBER SIGNATURE	**PATIENT SIGNATURE (UNLESS MINOR)**	**MONTH**	**DAY**	**YEAR**