Member Claim Form

Use this form only for out-of-network (OON) services or providers who decline to submit a claim directly to Community Health Options. Any approved covered service will be applied to the Member's OON accumulators and will be subject to balance billing. If you are seeking reimbursement for prescriptions, please use the Express Scripts reimbursement request form located on Community Health Options website.

Instructions: Please complete the entire form and submit it to Community Health Options at the address below.

Step 1: Complete all areas of the Member Claim Form before submitting the claim to us. (Submit separate claim forms for each family member.)

Step 2: Attach itemized bills and proof of payment for the services provided. Write the Member (patient) name and ID number on each attachment.

Be sure that you include the following required information on the form:

1. Subscriber Name and ID Number

2. Member (Patient) Name, Address, Date of Birth, and ID Number

3. Medical Provider Name and National Provider Identifier (NPI)

4. Medical Practice or Facility Name and Federal Tax ID Number (TIN/EIN), NPI, and Address where services were rendered

5. Detailed information for the rendered services, including the date(s) of service, diagnosis code(s) for the illness or injury that required treatment, procedure code(s) and any associated code modifiers that identify the rendered services, the number of units of service provided, the place of service (e.g. office, outpatient hospital, etc.), the amount charges for each service and the amount you paid for each service

Your claim may be denied if there is information missing on the claim form, or if proof of payment and/or itemized charges are not attached. Please call Member Services at the telephone number on the back of your ID card (M-F 8 a.m. to 6 p.m.) if you have questions.

Step 3: Sign, date, and send the Member Claim Form and all attachments to:

Community Health Options
Mail Stop 200
PO Box 1121
Lewiston, ME 04243

COMMUNITY Health Options®

SUBSCRIBER INFORMATION			
Last Name	First Name	M.I.	Subscriber ID #

MEMBER (PATIENT) INFORMATION			
Last Name	First Name	M.I.	Date of Birth
			/ /

Mailing Address	Member ID #

City	State	Zip Code

PROVIDER INFORMATION	
Provider Name	Provider NPI
Group/Facility Tax ID #	Group/Facility NPI
Provider Street Address	City, State Zip
Provider Mailing Address (if different)	City, State Zip

CLAIM(S) INFORMATION

Date of Service	Diagnosis Code	Procedure Code	Modifier	# of Units	Place of Service (POS)*	Charge Amount	Paid Amount**
/ /	-					$	$
/ /	-					$	$
/ /	-					$	$
					Totals	$	$

ATTESTATION AND SIGNATURE

I attest that the above information is true, accurate, and complete to the best of my knowledge, and that the services were received and paid for in the amount requested as indicated above. I acknowledge that if any information on this form is misleading or fraudulent, my coverage may be canceled, and I may be subject to criminal and/or civil penalties for false health care claims. I understand that when the claim is processed, it will contain information about the service (e.g., Provider name, date, description of service). I also understand that Community Health Options may request any additional information it deems necessary to verify that services were received and/or payment was made. I authorize any health care provider, medically related facility, insurance company, health care plan, and the Medical Information Bureau and their representatives to provide Community Health Options or their agents any and all information needed to complete the processing of this claim request; this may include complete medical history records, substance abuse records, and mental health records, for consideration of this claim and all future claims.

Print Name	Member/Guardian Signature	Date
		/ /

Proof of payment is required for processing

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