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 1-855-624-6463 (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

Member Claim Form

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

Community HEALTH OPTIONS®

NON-DISCRIMINATION NOTICE

Community Health Options does not view or treat people differently because of their race, color, national origin, sex, age or disability. If you need help with any of the information we provide you, please let us know. We offer services that may help you. These services include aids for people with disabilities, language assistance through interpreters and information written in other languages. These are free at no charge to you. If you need any of these services, please call us at the number on the back of your member ID card.

If you feel at any time that we didn't offer these services or we discriminated based on race, color, national origin, sex, age or disability, please let us know. You have the right to file a grievance, also known as a complaint. If you need help filing a complaint, please contact Nancy Johnson, Vice President of Compliance and Regulatory Affairs at P.O. Box 1121, Lewiston, ME 04243; by telephone at 1-855-624-6463 TTY/TDD 711; by email at Compliance@healthoptions.org; or by fax to 207-402-3318.

You can also contact the U.S. Department of Health and Human Services at the Office for Civil Rights at:

- Online: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
- Mail: U.S. Department of Health and Human Services
  200 Independence Avenue SW
  Room 509F, HHH Building
  Washington, DC 20201
- Phone: 1.800.368.1019 or 1.800.537.7697 (TDD)
- Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

French ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposes gratuitement. Appelez le 855-624-6463 (TTY/TDD: 711)	**Spanish** ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 855-624-6463 (TTY/TDD: 711)	**Chinese** 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 855-624-6463 (TTY/TDD: 711)。
Cushite XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 855-624-6463 (TTY/TDD: 711)	**Vietnamese** CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 855-624-6463 (TTY/TDD: 711)	**Arabic** مقر) 855-624-6463 مقرلاب لصتا .اناجم كل ةحاتم ةيوغللا ةدعاسملا تامدخ ،ةيبرعلا ملكتت تنك اذإ :هبتنإ مصلل يصنلا زاهجلا: 711).
Cambodian, Mon-Khmer យកចិត្តទុកដាក់: ប្រសិនបរ អ្ន នកនិយាយភាសា ខ្មែរ , ជារសវាគាំរទភាសាគអា ច សូមទូ សព្ទ: 855-624-6463 (711 TTY / TDD) ។	**Russian** ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 855-624-6463 (телетайп: 711)	**Tagalog** PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 855-624-6463 (TTY/TDD: 711).
German ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 855-624-6463 (TTY/TDD: 711).	**Thai** ียน: ถาี ี้ คุณพดู ภาษาไทยคุณสามารถใชบ้รก ี ารชว ี ยเหลอ ี ทางภาษาไดฟ้ ร โทร 855-624-6463 (TTY/TDD: 711).	**Nilotic-Dinka** PIŊ KENE: Na ye jam në Thuɔŋjaŋ, ke kuɔny yenë kɔc waar thook atɔ̈ kuka lëu yök abac ke cïn wënh cuatë piny. Yuɔpë 855-624-6463 (TTY/TDD: 711).
Korean 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 855-624-6463 (TTY/TDD: 711)번으로 전화해 주십시오.	**Polish** UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 855-624-6463 (TTY/TDD: 711).	**Japanese** 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。855-624-6463（TTY/TDD: 711）まで 、お電話にてご連絡ください。