MUTUAL MEDICAL Plans, Inc.®

MEDICAL CLAIM

Mail To:
Mutual Medical Plans, Inc.
P.O. Box 689
Peoria, IL 61652

PLEASE TYPE OR PRINT

1. **NAME OF PATIENT** (Last, First, and Initial) _____ **DATE OF BIRTH** Month ____ Day ____ Year ____ **SEX** Male ☐ Female ☐

RELATIONSHIP OF PATIENT TO EMPLOYEE Self ☐ Spouse ☐ Child ☐

If patient's last name is different from employee's, explain relationship. If patient is full time student, age 19 or over, state school and city.

2. **WHAT IS THE ILLNESS OR INJURY REQUIRING TREATMENT?** _____
(If injury, how did it happen?)

3. **WAS TREATMENT THE RESULT OF AN ACCIDENT?** Yes ☐ No ☐ **If yes, give:** Date of Accident ____ Place of Accident _____

4. **WAS ILLNESS OR INJURY IN ANY WAY WORK CONNECTED?** Yes ☐ No ☐

5. **IS PATIENT COVERED UNDER ANY OTHER HEALTH BENEFIT PLAN (individual or group)?** Yes ☐ No ☐
(IF "YES" COMPLETE THE REMAINDER OF THIS SECTION)

NAME OF INSURING CO. _____ **ADDRESS** _____

NAME OF POLICY HOLDER _____ **BIRTHDATE** Month ____ Day ____ Year ____ **SEX** Male ☐ Female ☐

RELATIONSHIP TO EMPLOYEE Self ☐ Spouse ☐ Child ☐ **TYPE OF COVERAGE (Self, Two Persons, Family, Etc.)** _____

IDENTIFICATION NUMBER OF OTHER COVERAGE _____ **EFFECTIVE DATE OF COVERAGE** Month ____ Day ____ Year ____

6. **TO BE COMPLETED REGARDLESS OF AGE OF PATIENT (SEE REVERSE SIDE FOR INSTRUCTIONS)**

IS THE PATIENT ENTITLED TO BENEFITS UNDER MEDICARE HOSPITAL INSURANCE (PART A) Yes ☐ **EFF.** Month ____ Day ____ Year ____ No ☐

IS THE PATIENT ENTITLED TO BENEFITS UNDER MEDICARE MEDICAL INSURANCE (PART B) Yes ☐ **EFF.** Month ____ Day ____ Year ____ No ☐

IF "YES" GIVE EFFECTIVE DATE OF ENROLLMENT FROM MEDICARE ID CARD _____

7. **NAME OF EMPLOYEE** (Last, First, and Initial) _____ **MEMBER LETTER AND NUMBER FROM ID CARD** _____

ADDRESS (Street) _____

City _____ State _____ Zip Code _____

I certify the above is correct and complete and I understand that cases of fraud will be criminally prosecuted. I authorize the release of any information necessary to process this claim.

_____ SIGNATURE OF EMPLOYEE

_____ DATE

_____ PHONE

ITEMIZED BILLS WITH DIAGNOSIS MUST BE ATTACHED
(SEE INSTRUCTIONS ON RESERVE SIDE)

ITEMIZED BILLS FOR COVERED SERVICES OR SUPPLIES
MUST BE ATTACHED AND THE ITEMIZED BILLS MUST CONTAIN:

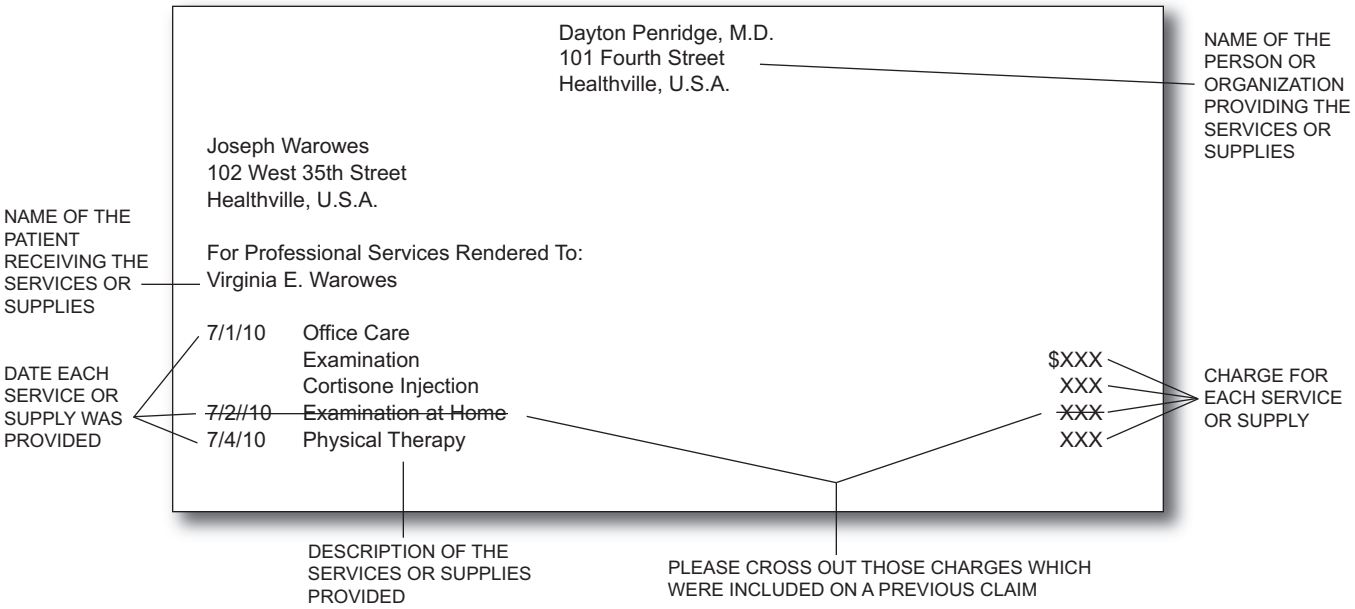
NAME OF THE PERSON OR ORGANIZATION PROVIDING THE SERVICES OR SUPPLIES
NAME OF THE PATIENT RECEIVING THE SERVICES OR SUPPLIES
DATE EACH SERVICE OR SUPPLY WAS PROVIDED
CHARGE FOR EACH SERVICE OR SUPPLY
DESCRIPTION OF THE SERVICES OR SUPPLIES PROVIDED

IN ADDITION:

BILLS FOR PRIVATE DUTY NURSING SERVICE MUST SHOW THE PROFESSIONAL STATUS OF THE NURSE, SUCH AS R.N. (Registered Nurse)
BILLS FOR PRESCRIPTION DRUGS MUST SHOW BOTH THE PRESCRIPTION NUMBER AND NAME FOR EACH DRUG
BILLS FOR DRUGS AND MEDICINES DISPENSED BY A PHYSICIAN MUST SHOW THE NAME OF EACH DRUG OR MEDICINE

ITEMIZED BILLS CANNOT BE RETURNED

EXAMPLE OF ITEMIZED BILL



When the patient is covered under Medicare Hospital Insurance (Part A), the "Notice of Health Insurance Utilization" form furnished by the Social Security Administration (or a mechanical reproduction thereof) pertaining to charges for which benefits are claimed herein must be attached to this claim form. When the patient is covered under Medicare Medical Insurance (Part B), the "Explanation of Benefits" form furnished by the Medicare Carrier (or a mechanical reproduction thereto) pertaining to charges for which benefits are claimed herein must be attached to this claim form.

This completed form, together with itemized bills and supporting material
should be submitted to

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