

**Medical Claims Settlement Submission Cover Sheet**

Download this form at [HTTP://www.claimsubmissionform.com](http://www.claimsubmissionform.com)

**Client Information:**

Date of Request: \_\_\_/\_\_\_/\_\_\_

Client Name: \_\_\_\_\_ Tel: (\_\_\_\_) \_\_\_\_ - \_\_\_\_

Name of Person Referring Claim: \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_ - \_\_\_\_

E-mail: \_\_\_\_\_ Website: \_\_\_\_\_

Reinsurer / Stop Loss: \_\_\_\_\_ MGU: \_\_\_\_\_

Group / Plan Name: \_\_\_\_\_ Group/Policy No.: \_\_\_\_\_

Effective Date \_\_\_/\_\_\_/\_\_\_ Contract Type: \_\_\_\_\_ Specific Deductible: \$ \_\_\_\_\_

**Patient Information:**

Patient Name: \_\_\_\_\_ ID No.: \_\_\_\_\_

Facility / Provider: \_\_\_\_\_ Tax ID: \_\_\_\_\_

DOS: From \_\_\_/\_\_\_/\_\_\_ To \_\_\_/\_\_\_/\_\_\_ Billed Charges: \$ \_\_\_\_\_

Is the provider in a Network? Yes No Network: \_\_\_\_\_

Discount: \$ \_\_\_\_\_ Discount Expires on: \_\_\_/\_\_\_/\_\_\_

**Please provide this information prior to claim submission:**

Patient Liability: \$ \_\_\_\_\_ Deductible / Out of Pocket owed: \$ \_\_\_\_\_

If we obtain a discount, can benefits be treated at the in-network level of benefits? Yes No

If yes, at what percentage are benefits payable? \_\_\_\_\_ Statutory Pmt Deadline: \_\_\_/\_\_\_/\_\_\_

When are checks cut for this group? \_\_\_\_\_

Has any payment been made on this bill? Yes No If yes, amount paid \$ \_\_\_\_\_

Comments / Special Instructions / Benefit Limitations:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Services Requested: Check your choice(s)**

- |                       |                   |                                |            |
|-----------------------|-------------------|--------------------------------|------------|
| Negotiated Settlement | Network Repricing | Medical Bill Review/Audit      | U&C Review |
| Treatment Plan Review | Pharmacy Sourcing | Pre-Screen for Maximum Savings |            |

**Please fax this completed form with provider bills to: EthiCare (866) 662-4121**