MHealth **The "Freedom of Choice" Plan**

P.O. Box 742547 – **Medical Claims**
Houston, Texas 77274-2547

CLAIM FORM

EMPLOYEE INFORMATION

Employer's Name: University of Texas System Medical Foundation		Group No.: UTSMFPPO or UTSMFEPO
Employee's Name:		Social Security No.
Date of Birth:	Sex: __Male __Female	Marital Status: __Single __Married __Widowed __Divorced
Current Mailing Address:		
City: State: Zip:		Telephone:

Spouse's Name:____ DOB:___________________ SS#:______________________
Name of Employer:____ Telephone:_________________________
Employer's Address:____ City:______________________________
State:_______________________________________ Zip Code:___________________________

PATIENT INFORMATION

Patient's Name: ____ DOB:________________________
Patient's Address: ____ City: ________________________
State: ____________________ Zip:_________________ Relationship to Member: ____

Marital Status: __Single __Married __Divorced __Widowed
If patient is a child age 19, is he/she registered as a full time student in an accredited College or University? __Yes __ No
If "Yes" give complete information:

- Name of College or University ____
- Address:____
- Telephone Number: (____)____

Describe the condition, illness or injury (IF ACCIDENT, STATE WHERE, HOW, DATE IT OCCURRED, AND IF IT WAS WORK RELATED)
____
____

COORDINATION OF BENEFITS

OTHER GROUP MEDICAL COVERAGE (This section must be completed)

1. Is the patient eligible for benefits under any other group medical plan? __Yes __No

2. If the answer to the above is "Yes", please provide:

a) Name and address of organization providing coverage ____
____
b) Policy/Group Number ____
c) Name and address of location where claims are processed ____
____

DIRECT PAYMENT

Assignments of Benefits

I hereby authorize payment directly to ____of the medical benefits due under this group policy, not to exceed the eligible charges submitted. I understand I am financially liable for charges not covered by this authorization. This assignment is valid only for the expense(s) accompanying this form and the Assignee indicated.

Employee Signature: ____ Date:_________________________

AUTHORIZATION

TO BE COMPLETED BY PATIENT – AUTHORIZATION TO OBTAIN INFORMATION

I AUTHORIZE the disclosure of relevant information about me for the purpose of evaluation and administering my claim.
I AUTHORIZE the following to disclose such information any physical, medical, professional, hospital, clinic other medical or medically related facility, insurance or reinsurance company, consumer reporting agency, medical or hospital service, prepaid health plan, employer, group policy holder, or benefit plan administrator. They may disclose such information to Memorial Hermann Health Network Providers, Inc. its reinsurers, consumer reporting agency, attorney, agent or independent administrator action on is behalf.
I UNDERSTAND that relevant information for claims purposes includes employment related information about medical care, advice, diagnosis, treatment, supplies provided, mental illness, and drug or alcohol use.
I UNDERSTAND that Memorial Hermann Health Network Providers, Inc. will not release the information EXCEPT to reinsuring companies, to other persons or organizations, performing businesses or legal services in connection with my claim, or as the law otherwise requires or permits.
I KNOW that I may receive a copy of this Authorization upon request.
I AGREE that a photographic copy of this Authorization shall be as valid as the original.
I AGREE that the Authorization shall be valid as follows:

a) For Claims of Health Insurance Benefits for one year from the date shown below or for the term of coverage of the policy, whichever is shorter, or
b) For all other claims, for one year from the date shown below for the duration of the claim, whichever is shorter.

I WARRANT that the information furnished on this claim form is accurate and complete and that providing false or misleading information is illegal.

Signature: ____Date: ________________________
Employee
Patient Signature – If not minor: ______________________________________Date: ____________________________

2457 06/05 Mail Completed Form and Itemized Bills To: MHealth
P.O. Box 742667 – Medical Claims, Houston, Texas 77274-2667