Draft

Peralta Medical Benefit for Flu Vaccination

CORESOURCE
A Trustmark Company
PERSONAL. FLEXIBLE. TRUSTED.

Union #1021 PPO Lite Plan

Medical Benefit	Preferred Provider	Nonpreferred Provider
Flu Vaccination	100% no deductible	No Coverage

Union #1021 PPO Traditional Plan

Medical Benefit	Preferred Provider	Nonpreferred Provider
Flu Vaccination	100% no deductible	80%

Union #39 PPO Lite Plan

Medical Benefit	Preferred Provider	Nonpreferred Provider
Flu Vaccination	100% no deductible	No Coverage

Union #39 PPO Traditional Plan

Medical Benefit	Preferred Provider	Nonpreferred Provider
Flu Vaccination	100% no deductible	80%

Pre 7/2004 Retiree Benefit Plan

Medical Benefit	Preferred Provider	Nonpreferred Provider
Flu Vaccination*	100% no deductible	80%

*Flu Vaccination falls under the Routine Preventive Care benefit which has a $250 maximum benefit per calendar year

10/14/2014

MAIL COMPLETED CLAIM FORM AND ITEMIZED BILLS TO:

Submit claims to:
Coresource
PO Box 2920
Clinton, IA 52733-2920

When submitting a claim, be sure to include your nine digit identification number (8 numeric digits ending in E). This number can be found on the front of your identification card.

Reminder!

(All claims not submitted within twelve (12) months from the date the services were rendered will not be a *covered expense* and will be denied) Refer to your SPD for additional details.

MEDICAL CLAIM FORM

EMPLOYEE INFORMATION	Employer's Name: ______ Employee's Name: ______ Date of Birth: ______ Phone Number: ______ Current Mailing Address: ______ ______	Blue Cross Group #: ______ Coresource Group # ______ ID #: ______ Gender: ☐ Male ☐ Female Marital Status: ☐ Single ☐ Divorced ☐ Widowed ☐ Married
SPOUSE INFORM-ATION	Spouse's Name: ______ Name of Employer: ______ Employer's Address: ______ ______	Social Security #: ______ Gender: ☐ Male ☐ Female Date of Birth: ______
PATIENT INFORMATION	Patient's Name: ______ Date of Birth: ______ Describe condition, illness or injury **(if accident, state where, how, date it occurred and if it was work related):** ______ ______ ______	Social Security #: ______ Gender: ☐ Male ☐ Female Marital Status: ☐ Single ☐ Divorced ☐ Widowed ☐ Married Relationship to Employee: ______

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:

Name and address of organization providing coverage: ______

______

Policy / Group Number: ______ Name and address of location where claims are to be processed: ______

DIRECT PAYMENT

ASSIGNMENT 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 that I am financially liable for charges not covered by this authorization. This assignment is valid only for expense(s) accompanying this form and the Assignee indicated.

Employee Signature: ______ Date: ______

AUTHORIZATION

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 policyholder, contract holder or benefit plan administrator. They may disclose such information to CoreSource, its reinsurers, consumers, reporting agency, attorney, agent or independent administrator action on its behalf.
I UNDERSTAND that relevant information for claims purposes includes employment-related information about medical care, advice, diagnosis, treatment, supplies provided, mental illness, and dug or alcohol use.
I UNDERSTAND that CoreSource will not release this information EXCEPT to reinsuring companies, to other persons or organizations performing business or legal services in connection with my claim, or as the law otherwise requires or permits.
I KNOW that a photographic copy of this Authorization shall be valid as the original...
I AGREE that this Authorization shall be valid as follows: 1) for Claims of Health Insurance Benefits, for 18 months from the date shown below or for the term of coverage of the policy, whichever is shorter; or 2) for all other claims for 18 months 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.

SIGN HERE (Employee): ______ Date: ______