MUTUAL HEALTH SERVICES℠

P.O. Box 5700 ♦ Cleveland, Ohio 44101
800-367-3762 ♦ Fax (330) 666-6685

Statement of Claim

PART A — EMPLOYEE MUST COMPLETE IN FULL

PATIENT'S NAME (FIRST NAME, MIDDLE INITIAL, LAST NAME)	PATIENT'S RELATIONSHIP TO INSURED	PATIENT'S SEX	PATIENT'S DATE OF BIRTH
	☐-Self ☐-Spouse ☐-Natural Child ☐-Other _____	☐ Male ☐ Female	/ /

EMPLOYEE NAME	EMPLOYEE'S HOME PHONE	EMPLOYEE ID NUMBER

ADDRESS (STREET, CITY, STATE, ZIP CODE)	GROUP NUMBER

IS CLAIM DUE TO INJURY OR ACCIDENT?	IF DUE TO INJURY OR ACCIDENT, DID IT OCCUR ON THE JOB?	DATE OF INJURY OR ACCIDENT
☐ Yes ☐ No	☐ Yes ☐ No	/ /

LOCATION	DESCRIBE BRIEFLY

IS PATIENT COVERED BY ANOTHER MEDICAL INSURANCE PLAN?	NAME, ADDRESS AND POLICY NO. OF INSURANCE CARRIER:
☐ Yes ☐ No	

SPOUSE'S EMPLOYER	ADDRESS (STREET, CITY, STATE, ZIP CODE)	SPOUSE'S SOCIAL SECURITY NUMBER

TO BE COMPLETED AND SIGNED BY THE EMPLOYEE IF DIRECT PAYMENT OF BENEFITS TO THE PHYSICIAN OR SURGEON IS DESIRED.
NOTE: ONCE BENEFITS ARE ASSIGNED, THE ASSIGNMENT CANNOT BE REVOKED

I authorize payment to be made directly to the provider.

Signature of Eligible Person _____ Date _____

AUTHORIZATION

1. I hereby authorize any hospital, physician, or other person who has attended or examined me to furnish to Mutual Health Services, Inc. all information with respect to this illness or accident, medical history, consultation, prescriptions, or treatment and copies of all hospital or medical records and permit the review, copying or photocopying of such records. A photocopy or fax of this authorization shall be considered as effective and valid as the original. If claim is on spouse, both husband and wife must sign.
2. Any person who, knowingly and with intent to deceive, files a statement of claim containing any materially false or misleading information is guilty of a crime. Please review this form thoroughly. Make certain all information is accurate and complete. Errors or omissions can result in payment delays or forfeiture of benefits. I certify that the information on this form is accurate and complete to the best of my knowledge.

Employee Signature _____ Date _____

PART B — TO BE COMPLETED BY PROVIDER OR SUPPLIER

PATIENT'S NAME (FIRST NAME, MIDDLE INITIAL, LAST NAME)	PATIENT'S RELATIONSHIP TO INSURED	PATIENT'S SEX	PATIENT'S DATE OF BIRTH
	☐ Self ☐ Spouse ☐ Natural Child ☐ Other _____	☐ M ☐ F	/ /

PATIENT'S ADDRESS	CITY, STATE, ZIP

DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. RELATE DIAGNOSIS TO PROCEDURE IN COLUMN D BY REFERENCE TO NUMBERS 1, 2, 3, ETC., OR BY DX CODE

DATE OF SERVICE	PLACE OF SERVICE	FULLY DESCRIBE PROCEDURE, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN Proc. Code (Identify) (Explain unusual services or circumstances)	DX CODE	CHARGES	WAS CONDITION RELATED TO PATIENT'S EMPLOYMENT
					Yes ____ No ____ AN ACCIDENT? Yes ____ No ____ DATE PATIENT FIRST SEEN FOR THIS CONDITION:

	TOTAL CHARGES	AMT. PAID	BALANCE

PHYSICIAN OR SUPPLIER NAME	ADDRESS, CITY, STATE, ZIP	PHONE

YOUR PATIENT ACCOUNT NO.	INDIVIDUAL PRACTITIONER - SOCIAL SECURITY NUMBER:	
	ALL OTHERS - EMPLOYER I.D. NUMBER:	

SIGNATURE OF PHYSICIAN OR SUPPLIER

Signed _____ Date _____

Multi-Language Interpreter Services & Nondiscrimination Notice

MUTUAL HEALTH SERVICES℠

This document notifies individuals of how to seek assistance if they speak a language other than English.

Spanish

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-367-3762.

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 1-800-367-3762。

German

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-367-3762.

Arabic

ملحوظة:إذاكنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان.اتصل برقم 1-800-367-3762 رقم هاتف الصم والبكم

Pennsylvania Dutch

Wann du Deitsch schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-800-367-3762.

Russian

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-367-3762.

French

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-367-3762.

Vietnamese

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-367-3762.

Navajo

Díí baa akó nínízin: Díí saad bee yáníłti' go Diné Bizaad, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh, éí ná hóló, kojį' hódíílnih 1-800-367-3762.

Oromo

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-800-367-3762.

Korean

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-367-3762 번으로 전화해 주십시오.

Italian

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-367-3762.

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。1-800-367-3762 まで、お電話にてご連絡ください。

Dutch

AANDACHT: Als u nederlands spreekt, kunt u gratis gebruikmaken van de taalkundige diensten. Bel 1-800-367-3762.

Ukrainian

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-800-367-3762.

Romanian

ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-800-367-3762.

Tagalog

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-367-3762.

QUESTIONS ABOUT YOUR BENEFITS OR OTHER INQUIRIES ABOUT YOUR HEALTH INSURANCE SHOULD BE DIRECTED TO MUTUAL HEALTH SERVICES' CUSTOMER CARE DEPARTMENT AT 1-800-367-3762.

Nondiscrimination Notice

Mutual Health Services complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex in its operation of health programs and activities. Mutual Health Services does not exclude people or treat them differently because of race, color, national origin, age, disability or sex in its operation of health programs and activities.

- Mutual Health Services provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters, and written information in other formats (large print, audio, accessible electronic formats, etc.).
- Mutual Health Services provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages.

If you need these services or if you believe Mutual Health Services failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, with respect to your health care benefits or services, you can submit a written complaint to the person listed below. Please include as much detail as possible in your written complaint to allow us to effectively research and respond.

Civil Rights Coordinator
Medical Mutual of Ohio
2060 East Ninth Street
Cleveland, OH 44115-1355
MZ: 01-10-1900

Email: CivilRightsCoordinator@MedMutual.com

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights.

- Electronically through the Office for Civil Rights Complaint Portal available at:
  ocrportal.hhs.gov/ocr/portal/lobby.jsf
- By mail at:
  U.S. Department of Health and Human Services
  200 Independence Avenue, SW Room 509F
  HHH Building
  Washington, DC 20201-0004
- By phone at:
  (800) 368-1019 (TDD: (800) 537-7697)
- Complaint forms are available at:
  hhs.gov/ocr/office/file/index.html

Products marketed by Medical Mutual may be underwritten by one of its subsidiaries, such as Medical Health Insuring Corporation of Ohio or Consumers Life Insurance Company.