# Claim Form

Complete all parts of the form, include any relevant documents received from the health care provider at the time of the health care service and proof of payment if applicable. **PLEASE SEND THE ORIGINAL BILLS NOT PHOTOCOPIES.** If any bills have been paid, please mark them 'PAID.'

**Return completed form to:** Aspirus Health Plan, Attn: Claims, PO Box 1062, Minneapolis, MN 55440

## MEMBER INFORMATION

| Employer *(if applicable)* | | | Group Number |
|---|---|---|---|
| Member Last Name | Member First Name | MI | Member ID Number |
| Member Address | City | State | Zip Code |
| Phone Number *(include area code)* | | | |
| Patient Name | Date of Birth | Relationship to Member ☐ Self ☐ Spouse ☐ Child | |

Are you, your spouse, and/or dependents covered under any other healthcare policy at the time the enclosed claim was incurred?

☐ No ☐ Yes *(If yes, please complete the following)*

| Company Name | | | Policy Number |
|---|---|---|---|
| Company Address | City | State | Zip Code |

Nature of illness or injury *(if accident, state when, where and how it occurred)*

## VISIT DETAILS

| Coding of the Health Care Service | | Date of Health Care Service |
|---|---|---|
| Health Care Provider Name | Place of Service | Billed Charges |

## MEMBER OR AUTHORIZED REPRESENTATIVE/GUARDIAN SIGNATURE

| **X** | Date |
|---|---|

*Important: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.*