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 1890, Southampton, PA 18966

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.