How to Complete This Medical Claim Form

Please complete this form completely and attach an original fully itemized bill(s) along with any supporting documentation.

1. The Member or Authorized Person must complete the following sections of the form:
   - Member
   - Patient Information
   - Accident Information
   - Medicare Information
   - Other Health Insurance
   - Authorization/Release of Information/Assignment of Benefits

2. Authorization/Release of Information
   Your signature authorizes GEHA to obtain information to carry out our processing of the claim(s).

3. Assignment of Benefits
   Your signature authorizes GEHA to pay the Provider or Supplier directly. Attach itemized documents supporting payment made on any portion of this claim.

4. Submitting the Claim Form
   COVID test claims: When you have purchased a COVID test from a recognized online entity or retail distributor, you must attach the following to the completed claim form: An itemized statement with all description details, complete cost and proof of purchase. Mail to PO Box 21542, Eagan, MN 55121. If you need assistance with completing this form, please contact GEHA at 800.821.6136.

   In-network medical claims: When you use a health care provider that is in GEHA's network, you will not have to fill out any claim forms in most cases. GEHA's in-network providers and facilities file claims for you as indicated on your ID card.

   Out-of-network medical claims: If you use an out-of-network provider, the claim may be submitted by either you or by the provider. Federal regulations require that a claim submitted by a provider must be filed on a CMS-1500 form. If you need to submit a medical claim yourself and you have an itemized bill, please attach and mail to PO Box 21542, Eagan, MN 55121. If you need assistance with completing this form, please contact GEHA at 800.821.6136.

GEHA
Government Employees Health Association

Medical Claim Form

See Page 1 for instructions on how to complete this claim form.

Member Information *(please print)*			
Last Name	First	MI	Subcriber ID Number

Patient Information – Complete this section only if claim is for a qualified dependent.			
Last Name	First		MI
Patient ID	Date of Birth	Relationship	Sex

Accident Information – Complete this section only if claim is result of accident or work-related illness or		
Date of accident or first symptoms of illness?	Where did the accident occur? (City/State)	Is accident/illness related to employment? If no, ☐ Auto ☐ Other
Describe the accident or illness.	Give date patient first consulted physician.	Has patient ever had same or similar symptoms? ☐ Yes ☐ No

Medicare Information – Complete this section only if patient is eligible for Medicare.			
Please attach copy of the "Explanation of Benefits" statement from your Medicare insurance carrier.	Medicare Number (include any alpha characters)	Effective Date Part A	Effective Date Part B

Other Health Insurance – If Yes, complete section below or claim cannot be processed. ☐ No other coverage			
Name of Policyholder	Policy Number	Name of Insurance Company/Phone	
Number Street Address	City	State	ZIP

Authorization/Release of Information

I authorize any insurance company, organization, employer, hospital physician, pharmacist or other health care provider to release any information requested with regard to this claim and the expenses reported. I certify that the information furnished in conjunction with this claim is true and correct. I know it is a crime to fill out this form with facts I know are false or to omit facts I know are important.

Patient or authorized person's signature _____ Date _____

Assignment of Benefits

I agree to assign benefits directly to the provider of services: _____ Date _____

Patient or authorized person's signature

THIS SECTION FOR PHYSICIAN OR SUPPLIER ONLY. If a detailed statement is available, please attach.

Provider Statement of Services Rendered

Name and address of facility where services were rendered (if other than home or office)	Date Admitted	Date Discharged

Diagnosis Code and Description
1. 3.
2. 4.

Date of Service (from/to)	Place of Service	CPT-4 Procedure Code	Description of Service	Charges	Days or Units	
Signature of Provider				Total Charge	Amount Paid	Balance Due

Provider Name	Tax ID Number
Provider Address	Telephone Number ( )