Health Insurance Claim Form

When completed mail to MMA, P.O. Box 483, Goshen, IN 46527. If you have a PPO, mail claims to the address on your membership card.

With this form, you must include the **original** bills or receipts from your physician, hospital, or pharmacy. The diagnosis, the date of service, the type of service, and the cost of each service must be indicated.

You may include several bills from providers and pharmacies – as long as they are for services received by the same person.

Patient information – for all claims

1. Name _____
   first middle initial last
2. Agreement no. (on your membership card) _____
3. Address _____
   street
   _____
   city state ZIP code
4. Is the patient covered as
   ☐ the policyholder ☐ dependent child
   ☐ spouse ☐ full-time student over age 18 (meeting required credit hours)
5. Is the patient covered by another insurance plan?
   ☐ yes ☐ no *If yes, give the policyholder's name, plan name, insurer's address, and telephone number.*
   _____
   _____
   _____

For physician and hospital claims

6. Was illness or condition related to patient's employment?
   ☐ yes ☐ no
7. Was illness or condition related to an accident?
   ☐ yes ☐ no
   If yes, auto or other? _____
   If yes, date of accident _____
8. Do you authorize the release of any medical information necessary to process this claim? ☐ yes ☐ no
9. Do you wish to have payment sent directly to your physicians or hospital? ☐ yes ☐ no
   If yes, list these providers below.
   _____
   _____
   _____

_____
Signature of insured or authorized person Date

For prescription drug claims

If you used your MMA prescription drug card to purchase your medication, your claim will be filed automatically. You need only complete this part of the claim form if you did not use your MMA prescription drug card.

Originals of drug bills or receipts must have the following information: date purchased, prescription number, pharmacy, patient, physician, drug, cost.

10. List each drug and the illness or condition being treated.
    _____
    _____
    _____

11. Do you wish to have payment sent directly to your pharmacy? ☐ yes ☐ no
    If yes, list the names and addresses of the pharmacies.
    _____
    _____
    _____

A person who submits an application or files a claim containing a false or deceptive statement, with the intent to defraud or facilitate a fraud against an insurer, may be guilty of insurance fraud. ***Not applicable in Virginia.***

In California: *Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.*

For office use only

_____
Agreement number

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