HONORHEALTH

HonorHealth Health Plan NOTICE OF CLAIM

Mail claim form and attachments to:
AmeriBen, PO Box 7186, Boise ID 83707
Or fax: 208-424-0595

This claim form needs to be filed every time you receive covered services from a provider that does not bill insurance for you. Please include with this claim form an itemized statement from your provider that includes patient name, date of service, total charges, the provider's tax ID number and procedure code(s).

PART 1: Employee Information

Employee Name (Last and First)	Employee Date of Birth		Employee Number	
Employee Address (Number, Street)		City	State	Zip

PART 2: Patient Information

Patient's Name	Patient's Date of Birth	

IS PATIENT ☐ EMPLOYEE ☐ CHILD ☐ SPOUSE ☐ OTHER Specify _____

PART 3: Description of Claim

Nature of Illness or Injury	Occupational Illness or Injury? ☐ YES ☐ NO	If claim is due to an accident state when, where and how accident occurred.
Have you been treated for this illness or injury in the last 12 months? ☐ YES ☐ NO		If yes, state the name and address of the attending physician.

PART 4: Other Group Health Insurance

Is patient eligible for Medicare Benefits? ☐ YES ☐ NO If yes, enter the date of eligibility _____

Are other family members employed?	Name, Relationship	Social Security Number	Name and Address of Employer
☐ YES ☐ NO If yes, indicate		- -	

Is patient covered under another group health insurance plan?	Name and address of other benefit carrier	Policy number
☐ YES ☐ NO If yes, indicate through plan of		
☐ SELF ☐ DEPENDENT		
☐ SPOUSE ☐ OTHER (specify)		

PART 5: Authorization

I hereby certify that the above statements are complete and accurate to the best of my knowledge. I also agree to reimburse the Plan to the extent of any overpayment which is in excess of the amounts payable under the benefit plan administered by the Plan. Any person who knowingly and with the intent to injury, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information may be guilty of a criminal act punishable under law.

Employee Signature: _____ Date _____

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I authorize payment directly to the Physician of the Surgical and/or Medical Benefits, if any, otherwise payable to me for the services submitted but not to exceed the reasonable and customary charge for those services	**Signed (Employee)** **Date**
AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the Physician to release any information acquired in the course of my examination or treatment.	**Signed (Patient or Parent if Minor)**