Member Claim Form



Please use a separate claim form for each patient. Your cooperation in completing all items on the claim form and attaching all required documentation will help expedite quick and accurate processing. SEE REVERSE SIDE FOR COMPLETE INSTRUCTIONS.

Last name First name M.I. Does the patient have other health insurance coverage? Relation to subscriber Sex Date of birth (MM/DD/YYYYY) Yes No Self Spouse Son Daughter M F Name of other health insurance company Group no. Employer name Policy no. Section B. SUBSCRIBER INFORMATION (on Bright Health ID Card) Identification no. Group no. Last name First name M.I. Street address (please include apt. no.) City State ZIP code Home phone no. Work phone no. Date of birth (MM/DD/YYYY) () Section C. MEDICAL INFORMATION HEALTH CARE SERVICES: Use this section to report any COVERED health service that has not already been reported to this Bright Health Plan by the provider of service (the physician, clinical, ambulance company, private duty nurse, etc.) Attach itemized bill or photocopy. Please be sure that duplicate bills are not submitted. Was this medical expense the result of an accident? Yes No Was this condition or injury job related? Yes No
Yes No
Yes No
Name of other health insurance company
Name of other health insurance company
Identification no. Group no. Last name First name M.I. Street address (please include apt. no.) City State Jerode Home phone no. () Section C. MEDICAL INFORMATION HEALTH CARE SERVICES: Use this section to report any COVERED health service that has not already been reported to this Bright Health Plan by the provider of service (the physician, clinical, ambulance company, private duty nurse, etc.) Attach itemized bill or photocopy. Please be sure that duplicate bills are not submitted. Was this medical expense the result of an accident?
Identification no. Group no. Last name First name M.I. Street address (please include apt. no.) City State Jerode Home phone no. () Section C. MEDICAL INFORMATION HEALTH CARE SERVICES: Use this section to report any COVERED health service that has not already been reported to this Bright Health Plan by the provider of service (the physician, clinical, ambulance company, private duty nurse, etc.) Attach itemized bill or photocopy. Please be sure that duplicate bills are not submitted. Was this medical expense the result of an accident?
Identification no. Group no. Last name First name M.I. Street address (please include apt. no.) City State Jerode Home phone no. () Section C. MEDICAL INFORMATION HEALTH CARE SERVICES: Use this section to report any COVERED health service that has not already been reported to this Bright Health Plan by the provider of service (the physician, clinical, ambulance company, private duty nurse, etc.) Attach itemized bill or photocopy. Please be sure that duplicate bills are not submitted. Was this medical expense the result of an accident?
Street address (please include apt. no.) City State ZIP code Home phone no. () Section C. MEDICAL INFORMATION HEALTH CARE SERVICES: Use this section to report any COVERED health service that has not already been reported to this Bright Health Plan by the provider of service (the physician, clinical, ambulance company, private duty nurse, etc.) Attach itemized bill or photocopy. Please be sure that duplicate bills are not submitted. Was this medical expense the result of an accident?
Street address (please include apt. no.) City State ZIP code Home phone no. () Section C. MEDICAL INFORMATION HEALTH CARE SERVICES: Use this section to report any COVERED health service that has not already been reported to this Bright Health Plan by the provider of service (the physician, clinical, ambulance company, private duty nurse, etc.) Attach itemized bill or photocopy. Please be sure that duplicate bills are not submitted. Was this medical expense the result of an accident?
City State ZIP code Home phone no. Work phone no. Date of birth (MM/DD/YYYY) () Section C. MEDICAL INFORMATION HEALTH CARE SERVICES: Use this section to report any COVERED health service that has not already been reported to this Bright Health Plan by the provider of service (the physician, clinical, ambulance company, private duty nurse, etc.) Attach itemized bill or photocopy. Please be sure that duplicate bills are not submitted. Was this medical expense the result of an accident?
City State ZIP code Home phone no. Work phone no. Date of birth (MM/DD/YYYY) () Section C. MEDICAL INFORMATION HEALTH CARE SERVICES: Use this section to report any COVERED health service that has not already been reported to this Bright Health Plan by the provider of service (the physician, clinical, ambulance company, private duty nurse, etc.) Attach itemized bill or photocopy. Please be sure that duplicate bills are not submitted. Was this medical expense the result of an accident?
Home phone no. ()
Home phone no. ()
Home phone no. ()
Section C. MEDICAL INFORMATION HEALTH CARE SERVICES: Use this section to report any COVERED health service that has not already been reported to this Bright Health Plan by the provider of service (the physician, clinical, ambulance company, private duty nurse, etc.) Attach itemized bill or photocopy. Please be sure that duplicate bills are not submitted. Was this medical expense the result of an accident?
Section C. MEDICAL INFORMATION HEALTH CARE SERVICES: Use this section to report any COVERED health service that has not already been reported to this Bright Health Plan by the provider of service (the physician, clinical, ambulance company, private duty nurse, etc.) Attach itemized bill or photocopy. Please be sure that duplicate bills are not submitted. Was this medical expense the result of an accident?
HEALTH CARE SERVICES: Use this section to report any COVERED health service that has not already been reported to this Bright Health Plan by the provider of service (the physician, clinical, ambulance company, private duty nurse, etc.) Attach itemized bill or photocopy. Please be sure that duplicate bills are not submitted. Was this medical expense the result of an accident? Yes No Was this condition or injury job related?
HEALTH CARE SERVICES: Use this section to report any COVERED health service that has not already been reported to this Bright Health Plan by the provider of service (the physician, clinical, ambulance company, private duty nurse, etc.) Attach itemized bill or photocopy. Please be sure that duplicate bills are not submitted. Was this medical expense the result of an accident? Yes No Was this condition or injury job related?
Bright Health Plan by the provider of service (the physician, clinical, ambulance company, private duty nurse, etc.) Attach itemized bill or photocopy. Please be sure that duplicate bills are not submitted. Was this medical expense the result of an accident?
Was this medical expense the result of an accident? □ Yes □ No Was this condition or injury job related? □ Yes □ No
Was this condition or injury job related? □ Yes □ No
Was this condition or injury job related? □ Yes □ No
Have you filed for Workers' Compensation? □ Yes □ No
When did this injury or accident occur? (MM/DD/YYYY)/ Diagnosis code
Diagnosis code Date of Service Procedure code Amount Charged
BILLS MUST BE ITEMIZED
Cancelled checks, cash register receipts and non-itemized "balance due" statements cannot be processed. Each itemized bill must include:
Name and address of provider (doctor, hospital, laboratory, ambulance service, Tax ID, etc.)
Name of patient
 Procedure code Date of service
Amount charged for each service
• Diagnosis code
I certify that, to the best of my knowledge, the information on this Member Claim Form is true and correct. I authorize the release of any medical information necessary to process this claim.
Signature Name Date

HOW TO USE THIS FORM

Most health care providers will submit bills to Bright Health on you or your dependent's behalf. However, if a physician does not bill us they may bill you directly. If you receive a bill from your a health care provider you may use this claim form to submit the charges to Bright Health.

Please read the following instructions for submitting the claim to report the claim to Bright Health.

SECTION A. PATIENT INFORMATION

Use this section to identify the patient.

SECTION B. SUBSCRIBER INFORMATION (on Bright Health ID card)

Use this section to identify the subscriber. Some of this information may be found on your Bright Health card.

SECTION C. MEDICAL INFORMATION: This section pertains to the employee through whose employer your program is obtained

Health Care Services: Use this section to report that has not already been reported to Bright Health. Attach a photocopy of an itemized bill.

MEMBER CLAIM FORM INSTRUCTIONS:

Please mail this claim form and a photocopy of your itemized bill to:

Bright Health PO Box 16275 Reading, PA 19612-6275