

Member Claim Form

MEDICAL/DENTAL/VISION SEE REVERSE SIDE FOR CLAIM FILING INSTRUCTIONS

Prominence Health Plan Claims Department 1510 Meadow Wood Lane Reno, NV 89502

ENTIRE THE SERVICE REQUIRED AS A SENT OF SERVICE OF SPOUSE CHILD OTHER COORDINATION OF BENEFITS INFORMATION COORDINATION OF BENEFITS INFORMATION OF BENEFITS INFORMATION COORDINATION OF BENEFITS INFORMATION OF BENEFITS INF	1. SUBSCRIBER NUMBER 2. GROUP NUMBER			3. PATIENT NAME (Last, First, Initial) (PLEASE PRINT)						4. PATIENT BIRTHDATE MO DAY YR.			
SUBSCRIBER ADDRESS (SINCE, City, State, Zip Code) COORDINATION OF BENEFITS INFORMATION WERE THESE SERVICES REQUIRED AS A BESULT OF A COLDENT YES NO SERVICES REQUIRED AS A BESULT OF S. NAME AND ADDRESS OF EMPLOYER YES NO IN OUR SERVICES REQUIRED FOR A CONDITION RESIDENTIAL FROM AN ACCIDENT IN OUR SERVICES REQUIRED FOR A CONDITION RESIDENTIAL FROM AN ACCIDENT IN OUR DOES RECORDED FOR A CONDITION RESIDENTIAL FROM AN ACCIDENT IN OUR OF OUR SERVICES REQUIRED FOR A CONDITION RESIDENTIAL FROM AN ACCIDENT IN OUR OUR DOES REPORT AND RESIDENTIAL FROM AN ACCIDENT IN OUR OUR OUR SERVICES AND FROM THE FROM AN ACCIDENT IN OUR OUR OUR SERVICES AND FROM THE FROM AN ACCIDENT WERE NO IN MEMBEERS ID RUMBER IN OUR SERVICES AND FROM THE FROM AND FROM FROM THE FROM AN ACCIDENT MEDICAL SERVICE INFORMATION IN MEMBEERS ID RUMBER IN OUR SERVICES AND FROM THE FROM AND FROM FROM THE FROM AND FROM FROM THE FRO	. PATIENT SEX	6. PATIENT	RELATIONSHIP T	O SUBSCRIBER				7. SUBSCRIE	BER NAME (Last	, First, Initial)	İ	<u> </u>	
COORDINATION OF BENEFITS INFORMATION A WEBS THESS SERVICES REQUIRED AS A RESULT OF SA NAME AND ADDRESS OF EMPLOYER A WEBS THESS SERVICES REQUIRED AS A RESULT OF SA NAME AND ADDRESS OF EMPLOYER BY DO SO TO QUESTION 10 BY BY DO SO TO QUESTION 10 BY BY BY DO SO TO QUESTION 11 LEAR ANY FAMILY MARRIES SCRIPPAS COVERED BY THE MADE ADDRESS OF INSULANCE COMPANY OR ADMINISTRATOR ILLA MEANY FAMILY MARRIES SCRIPPAS COVERED BY THE MADE AND ADDRESS OF INSULANCE COMPANY OR ADMINISTRATOR ILLA MEANY FAMILY MADERIES SCRIPPAS COVERED BY THE MADE AND ANY PEDRAL STATE BY THE MADE AND ANY PEDRAL STATE BY THE MADE AND ANY PEDRAL STATE BY THE MADE ANY PEDRAL STATE BY THE MADE AND ANY PEDRAL STATE BY	MALE FEMAI	E SE	LF	SPOUSE	CHILD	(OTHER						
AND A STATE OF ACCIDENT (A) OF BEAUTION THE STREWS CHARGE REQUIRED AN A RESULT OF ACCIDENT (A) OF BOO TO QUESTION 10 (B) NEWS EXPLICES REQUIRED POR A CONDITION RESULTING PROM AN ACCIDENT (NO FOR GO TO QUESTION 10 (B) NEWS EXPLICES REQUIRED POR A CONDITION RESULTING PROM AN ACCIDENT (NO FOR GO TO QUESTION 11 (I) ARE ARY PAMINY HARBINER AND POR ACCIDENT OR INVURY (MANDDYTYYY) FOR GO TO QUESTION 12 (I) ARE ARY PAMINY HARBINER AND POR ANY FEDERAL, STATE, IN AMBIE ADDRESS OF INSURANCE COMPANY OR ADMINISTRATOR (I) ARE ARY PAMINY HARBINER AND RAWN FEDERAL, STATE, IN AMBIE ADDRESS OF INSURANCE COMPANY OR ADMINISTRATOR (I) ARE ARY PAMINY HARBINER AND RAWN FEDERAL, STATE, IN AMBIE ADDRESS OF INSURANCE COMPANY OR ADMINISTRATOR (I) ARRIVER CASE OF SERVICE INFORMATION (I) ARRIVER CASE OF A STATE OR AND FEDERAL STATE, IN AMBIE ADDRESS OF INSURANCE COMPANY OR ADMINISTRATOR (I) ARRIVER CASE OF A STATE OR ACCIDENT OR INJURY (MANDDYTYYY) (II) ARRIVER CASE OF A STATE OR ACCIDENT OR INJURY (MANDDYTYYY) (II) ARRIVER CASE OF A STATE OR ACCIDENT OR INJURY (MANDDYTYYY) (II) ARRIVER CASE OF A STATE OR ACCIDENT OR INJURY (MANDDYTYYY) (II) ARRIVER CASE OF A STATE OR ACCIDENT OR INJURY (MANDDYTYYY) (II) ARRIVER CASE OF ACCIDENT OR INJURY (MANDDYTYY) (II) ARRIVER CASE OF ACCIDENT OR INJURY (MANDDYTYYY) (II) ARRIVER CASE OF ACCIDENT OR INJURY (MANDDYTYY) (II) ARRIVER CASE OF ACCIDENT OR INJURY (MANDDYTYY) (II) ARRIVER CASE OF ACCIDENT OR INJURY (MANDDYTYY) (II) ARRIVER CASE OF ACCIDENT	3. SUBSCRIBER ADDRESS (Street, City, Stat	e, Zip Code)						•					
NOB REPROVED TO QUISTION 10 WE SERVICE SERVICE POR A CONDITION RESULTING FROM AN ACCIDENT NO WEST SERVICE SEQUENCE FOR A CONDITION RESULTING FROM AN ACCIDENT NO WEST SERVICES REQUISED FOR A CONDITION RESULTING FROM AN ACCIDENT NO WEST SERVICES REQUISED FOR A CONDITION RESULTING FROM AN ACCIDENT NO WEST SERVICES REQUISED FOR A CONDITION RESULTING FROM AN ACCIDENT NO RIVING CAUSED BY ANOTHER MARTY VES NO IL ALEA MAY PARILY MARMERS EXPENDES COVERED BY NO WEST SERVICES SUPPLIES SERVICES OF BUSINANCE COMPANY OR ADMINISTRATOR IL ALEA MAY PARILY MARMERS EXPENDES COVERED BY NESS NO IL ALEA MAY PARILY MARMERS EXPENDES COVERED BY NESS NO IL ALEA MARTINE AND AN ANY PERIPAL, STATE, VES NO IL ALEA MEDICARE PART A AND/OR PART B P			С	OORDINATION (OF BENEF	ITS INFOR	MATION						
IN OLD TO QUISTION 1 ID WERE SERVICES REQUISED FOR A CONDITION RESULTING FROM AN ACCIDENT OR INDIREY CAUSED BY ANOTHER PARTY YE'S NO RECORD TO QUISTION 1 ID ILL ARE ANY SEMILY MEMBERS EXPENSES COVERED BY NO CO TO QUISTION 1 ID ILL ARE ANY SEMILY MEMBERS EXPENSES COVERED BY NO ILL AMERICAN SEMILAR AND AN ANY FIDERAL, STATE YES NO ILL AMERICAN SEMILAR AND AN ANY FIDERAL, STATE YES NO ILL AMERICAN SEMILAR AND AN ANY FIDERAL, STATE YES NO ILL AMERICAN SEMILAR AND AND ANY FIDERAL, STATE YES NO ILL AMERICAN SEMILAR AND AND ANY FIDERAL, STATE YES NO ILL AMERICAN SEMILAR AND AND ANY FIDERAL, STATE YES NO ILL AMERICAN SEMILAR AND AND ANY FIDERAL, STATE YES NO ILL AMERICAN SEMILAR AND AND ANY FIDERAL, STATE YES NO ILL AMERICAN SEMILAR AND ANY FIDERAL, STATE YES NO ILL AMERICAN SEMILAR AND ANY FIDERAL, STATE YES NO ILL AMERICAN SEMILAR AND ANY FIDERAL, STATE PROCEDICAL SERVICE INFORMATION ILL AMERICAN SEMILAR AND ANY FIDERAL, STATE ***ENDICAL SERVICE**** INFORMATION ***ENDICAL SERVICE**** INFORMATION ***INDICAL SERVICE***** INFORMATION ***INDICAL SERVICE***** INFORMATION ***INDICAL SERVICE***** INFORMATION ***INDICAL SERVICE***** INFORMATION ***INDICAL SERVICE****** INFORMATION ***INDICAL SERVICE************************************	A JOB-RELATED ILLNESS OR ACCIDENT		NAME AND ADDR	ESS OF EMPLOYER					9c. DAT	E OF ACCIDENT			
DIR INDURY CAUSED BY ANOTHER PARTYY YES NO ILL ARE ANY PANDLY MEMBERS EXPENSIS COVERED BY LENG OF TO QUESTION 1 ILL ARE ANY FAMILY MEMBERS EXPENSIS COVERED BY LENG OF TO QUESTION 1 ILL ARE ANY FAMILY MEMBERS EXPENSIS COVERED BY LENG OF TO QUESTION 1 ILL ARE ANY FAMILY MEMBERS EXPENSIS COVERED BY LENG OF TO QUESTION 1 ILL ARE ANY FAMILY MEMBERS EXPENSIS COVERED BY LENG OF TO QUESTION 1 ILL ARE ANY FAMILY MEMBERS BY PLAN OR ANY FEDERAL, STATE LENG OF TO QUESTION 1 ILL ARE MEMBERS IN NUMBER ILL ARE AND FAMILY MEMBERS BY LACE OF SERVICE AND AND AND AND AND ANY FEDERAL, STATE LENG OF TO QUESTION 1 ILL ARE SEQUENTIAL TO ANY FEDERAL STATE AND PHONE NUMBER ILL ARE SEQUENTIAL TO ANY FEDERAL STATE AND PHONE NUMBER ILL ARE SEQUENTIAL TO ANY FEDERAL STATE AND PHONE NUMBER ILL ARE SEQUENTIAL TO ANY FEDERAL STATE AND PHONE NUMBER ILL ARE SEQUENTIAL STATE AND ANY FEDERAL STATE AND PHONE NUMBER ILL ARE SEQUENTIAL STATE AND ANY FEDERAL STATE AND PHONE NUMBER ILL ARE SEQUENTIAL STATE AND ANY FEDERAL STATE AND PHONE NUMBER ILL ARE SEQUENTIAL STATE AND ANY FEDERAL STATE AND PHONE NUMBER ILL ARE SEQUENTIAL STATE AND ANY FEDERAL STATE AND PHONE NUMBER ILL ARE SEQUENTIAL STATE AND ANY FEDERAL STATE AND PHONE NUMBER ILL ARE SEQUENTIAL STATE AND ANY FEDERAL STATE AND PHONE NUMBER ILL ARE SEQUENTIAL STATE AND ANY FEDERAL STATE AND PHONE NUMBER ILL ARE SEQUENTIAL STATE AND ANY FEDERAL STATE ANY FEDERAL STATE AND ANY FEDERAL STATE AND ANY FEDERAL STATE ANY FEDERAL STATE ANY FEDERAL STATE AND ANY FEDERAL STATE ANY FEDERAL													
IL ARE ANY FAMILY MEABLES EXPENSES COVERED BY NO SUMMOTHER GROUP PLAN? NO IL MEMBERS IN INDEED IN ANY FEDERAL, STATE, SINCELE GOVERNMENT PLAN? YES NO IL MEMBERS IN NUMBER ILI MEMBERS NAME (LAST, FIRST, INITIAL) ILI MEMBERS SERVICE FOR MEDICARE PART A AND/OR PART B PART A YES NO MEDICAL/SERVICE INFORMATION ILILISIS OR SYMPTOMS (DIAGNOSIS CODE FROM ITEMIZED STATEMENT) FOR REMINUSEMENT 4. NAME OF PROVIDER WHO RENDERED THE SERVICE AND PHONE NUMBER NAME PHONE NO. PLEASE COMPLETE THE FOLLOWING AS A SUMMARY OF THE ITEMIZED BILLS YOU HAVE ATTACHED TO THIS CLAIM FORM PLEASE COMPLETE THE FOLLOWING AS A SUMMARY OF THE ITEMIZED BILLS YOU HAVE ATTACHED TO THIS CLAIM FORM 7. DATE OF SERVICE IS SERVICE IS SERVICE OF SERVICES OP OUTPATIENT HOSPITAL PROVIDE BRIEFLY DESCRIBE THE SERVICES) YOU RECEIVED 1. LTOTAL CHARGES FOR WHICH YOU RESERVICE OF SERVICE OF OUTPATIENT HOSPITAL I. LAB PHANE OF PROVIDENT HOSPITAL IP - INPATIENT HOSPITAL 1. LAB PHANE OF SERVICE OF OUTPATIENT HOSPITAL IP - INPATIENT HOSPITAL I. LAB PHANE OF SERVICE OF PART B NH. HOME NH. NUSRING HOME PHANE OF ADMINISTRATOR III. EMPLOYER NAME/GROUP NUMBER II. EMPLOYER NAME/GROUP NUMBER III. EMPLOYER NAME/GROUP NUMBER III. EMPLOYER NAME/GROUP				CCIDENT				1	0a. DATE OF A	CCIDENT OR INJ	URY (MM/I	DD/YYYY)	
ANOTHER GROUP HEALTH HAN OR ANY FEDERAL STATE RESIDENTIFIED STATE OF SERVICE 11.4 MEMBERS IN NUMBER 11.4 MEMBERS NAME (LAST, FIRST, INITIAL) 11.5 MEMBERS BIRTHDATE (MM/DD/YYYY) 12.4 MEDICARE NUMBER 2.5 SATIENT ELIGIBLE FOR MEDICARE PART A AND/OR PART B PAR		EC COVEDED BY	I 11- NAME/AD	DDESC OF INCLIBANCE	COMBANIVO	A DMINIETD A	TOR		11 EMBLOVED	NA ME/CROUD N	HIMDED		
ILE MEMBER'S ID NUMBER ILE MEMBER'S ID NUMBER ILE MEMBER'S ID NUMBER ILE MEMBER'S ID NUMBER ILE MEMBER'S BIRTHDATE (MM/DD/YYYY) ILE MEMBER'S BIRTHDATE (MM/DD/YYYYY) ILE MEMBER'S BIRTHDATE (MM/DD/YYYYY) ILE MEMBER'S BIRTHDATE (MM/DD/YYYYY) ILE MEMBER'S BIRTHDATE (MM/DD/YYYYY) ILE MEMBER'S BIRTHDATE (MM/DD/YYYYYYYYYYYYYYYYYYYYYYYYYYYYYYYYY	ANOTHER GROUP HEALTH PLAN OR AI DR LOCAL GOVERNMENT PLAN?		1	DRESS OF INSURANCE	COMPANY OF	R ADMINIST RA	IIOK		I Ib. EMPLOYER	NAME/GROUP N	NUMBER		
IS ILLINESS OR SYMPTOMS (DIAGNOSIS CODE FROM ITEMIZED STATEMENT) FOR REIMBURSEMENT 14. NAME OF PROVIDER WHO RENDERED THE SERVICE AND PHONE NUMBER NAME PHONE NO. 15. IF PLACE OF SERVICE WAS OUTPATIENT OR INPATIENT HOSPITAL, PROVIDE NAME PHONE NO. 16. IF WE HAVE QUESTIONS, WHO MAY WE CONTACT? NAME PHONE NO. 17. DATE OF SERVICE SERVICE 18. PLACE OF SERVICE 19. CHARGE FOR SERVICE 20. BRIEFLY DESCRIBE THE SERVICE(S) YOU RECEIVED 21. TOTAL CHARGES FOR WHICH YOU ARREPED TO PHONE NO. 22. TOTAL CHARGES FOR WHICH YOU ARREPED TO PHONE NO. 23. TOTAL CHARGES FOR WHICH YOU ARREPED TO PHONE NO. 24. PLACE OF SERVICE 25. OP - OUTPATIENT HOSPITAL PROVIDE NH. NUKSING HOME P PHARMACY 16. IF WE HAVE QUESTION ON SIDERATION AND THE PROVIDE NAME OF THE PLACE OF SERVICE WAS OUTPATIENT HOSPITAL L. L. LAB 15. IF PLACE OF SERVICE WAS OUTPATIENT HOSPITAL PROVIDE NAME OF HOSPITAL FACILITY 16. PLACE OF SERVICE WAS OUTPATIENT HOSPITAL PROVIDE NAME OF HOSPITAL FACILITY 17. DATE OF SERVICE 26. BRIEFLY DESCRIBE THE SERVICE(S) YOU RECEIVED 27. PLACE OF SERVICE 28. PLACE OF SERVICE 29. OUTPATIENT HOSPITAL P INPATIENT HOSPITAL L. L. LAB 29. PARKMENTY S. NO. OUTPATIENT HOSPITAL N.				MBER'S NAME (LAST, FIRST, INITIAL)					11e. MEMBER'S BIRTHDATE (MM/DD/YYYY)				
### PACE OF SERVICE INFORMATION ### PACE OF SERVICE INFORMATION 13. ILLNESS OR SYMPTOMS (DIAGNOSIS CODE FROM ITEMIZED STATEMENT) FOR REIMBURSEMENT 14. NAME OF PROVIDER WHO RENDERED THE SERVICE AND PHONE NUMBER NAME PHONE NO. 15. IF PLACE OF SERVICE WAS OUTPATIENT OR INPATIENT HOSPITAL, PROVIDE NAME OF HOSPITAL FACILITY 15. IF PLACE OF SERVICE WAS OUTPATIENT OR INPATIENT HOSPITAL, PROVIDE NAME OF HOSPITAL FACILITY 16. IF WE HAVE QUESTIONS, WHO MAY WE CONTACT? PHONE NO. 16. IF WE HAVE QUESTIONS, WHO MAY WE CONTACT? PHONE NO. 17. DATE OF SERVICE 18. PLACE OF SERVICE 19. CHARGE FOR SERVICE 20. 8RIEFLY DESCRIBE THE SERVICE(S) YOU RECEIVED 17. DATE OF SERVICE 18. PLACE OF SERVICE 20. 8RIEFLY DESCRIBE THE SERVICE(S) YOU RECEIVED 18. PLACE OF SERVICE 19. CHARGE FOR SERVICE 20. 9. PLACE OF SERVICE 20. 19. PLACE OF SERVICE 20.													
13. ILINESS OR SYMPTOMS (DIAGNOSIS CODE FROM ITEMIZED STATEMENT) FOR REIMBURSEMENT 14. NAME OF PROVIDER WHO RENDERED THE SERVICE AND PHONE NO. 15. IF PLACE OF SERVICE WAS OUTPATIENT OR INPATIENT HOSPITAL, PROVIDE NAME OF HOSPITAL FACILITY NAME PHONE NO. 16. IF WE HAVE QUESTIONS, WHO MAY WE CONTACT? NAME PHONE NO. 17. DATE OF SERVICE IS, PLACE OF SERVICE O		PART A AND/OR P						12a	12a. MEDICARE NUMBER				
14. NAME OF PROVIDER WHO RENDERED THE SERVICE AND PHONE NUMBER NAME PHONE NO. 16. IF WE HAVE QUESTIONS, WHO MAY WE CONTACT? NAME PHONE NO. PLEASE COMPLETE THE FOLLOWING AS A SUMMARY OF THE ITEMIZED BILLS YOU HAVE ATTACHED TO THIS CLAIM FORM 7. DATE OF SERVICE 9. CHARGE FOR SERVICE 20. BRIEFLY DESCRIBE THE SERVICE(S) YOU RECEIVED 20. BRIEFLY DESCRIBE THE SERVICE(S) YOU RECEIVED 21. TOTAL CHARGES FOR WHICH YOU ARE REQUISTING CONSIDERATION 22. TOTAL CHARGES FOR WHICH YOU ARE REQUISTING CONSIDERATION 24. PLACE OF SERVICE 25. O OFFICE OF OUTPATIENT HOSPITAL IP - INPATIENT HOSPITAL L- LAB OF PAYMENT? 36. IF PLACE OF SERVICE OF OP - OUTPATIENT HOSPITAL IP - INPATIENT HOSPITAL L- LAB OF PAYMENT?				MEDICAL/SI	ERVICE IN	FORMATION	NC						
NAME PHONE NO. 15. IF PLACE OF SERVICE WAS OUTPATIENT OR INPATIENT HOSPITAL, PROVIDE NAME OF HOSPITAL FACILITY NAME OF HOSPITAL FACILITY 15. IF PLACE OF SERVICE WAS OUTPATIENT OR INPATIENT HOSPITAL, PROVIDE NAME OF HOSPITAL FACILITY 16. IF WE HAVE QUESTIONS, WHO MAY WE CONTACT? NAME OF HOSPITAL FACILITY 17. DATE OF SERVICE 19. CHARGE FOR SERVICE 20. BRIEFLY DESCRIBE THE SERVICE(S) YOU RECEIVED 18. PLACE OF SERVICE SERVICE SERVICE OF DETAILS THE SERVICE SERVICE SERVICE OF	3. ILLNESS OR SYMPTOMS (DIAGNOSIS	CODE FROM ITEM	IZED STATEMENT	T) FOR REIMBURSEMEN	ΙΤ								
AME OF HOSPITAL FACILITY NAME PHONE NO. PLEASE COMPLETE THE FOLLOWING AS A SUMMARY OF THE ITEMIZED BILLS YOU HAVE ATTACHED TO THIS CLAIM FORM 7. DATE OF SERVICE SERVICE 20. BRIEFLY DESCRIBE THE SERVICE(S) YOU RECEIVED PLEASE COMPLETE THE FOLLOWING AS A SUMMARY OF THE ITEMIZED BILLS YOU HAVE ATTACHED TO THIS CLAIM FORM PLEASE COMPLETE THE FOLLOWING AS A SUMMARY OF THE ITEMIZED BILLS YOU HAVE ATTACHED TO THIS CLAIM FORM PRINTING OF SERVICE 20. BRIEFLY DESCRIBE THE SERVICE(S) YOU RECEIVED PRINTING OF THE ITEMIZED BILLS YOU HAVE ATTACHED TO THIS CLAIM FORM PRINTING OF THE ITEMIZED BILLS YOU HAVE ATTACHED TO THIS CLAIM FORM PRINTING OF THE ITEMIZED BILLS YOU HAVE ATTACHED TO THIS CLAIM FORM PRINTING OF THE ITEMIZED BILLS YOU HAVE ATTACHED TO THIS CLAIM FORM PRINTING OF THE ITEMIZED BILLS YOU HAVE ATTACHED TO THIS CLAIM FORM PRINTING OF THE ITEMIZED BILLS YOU HAVE ATTACHED TO THIS CLAIM FORM PRINTING OF THE ITEMIZED BILLS YOU HAVE ATTACHED TO THIS CLAIM FORM PRINTING OF THE ITEMIZED BILLS YOU HAVE ATTACHED TO THIS CLAIM FORM PRINTING OF THE ITEMIZED BILLS YOU HAVE ATTACHED TO THIS CLAIM FORM PRINTING OF THE ITEMIZED BILLS YOU HAVE ATTACHED TO THIS CLAIM FORM PRINTING OF THE ITEMIZED BILLS YOU HAVE ATTACHED TO THIS CLAIM FORM PRINTING OF THE ITEMIZED BILLS YOU HAVE ATTACHED TO THIS CLAIM FORM PRINTING OF THE ITEMIZED BILLS YOU HAVE ATTACHED TO THIS CLAIM FORM PRINTING OF THE ITEMIZED BILLS YOU HAVE ATTACHED TO THIS CLAIM FORM PRINTING OF THE ITEMIZED BILLS YOU HAVE ATTACHED TO THIS CLAIM FORM PRINTING OF THE ITEMIZED BILLS YOU HAVE ATTACHED TO THIS CLAIM FORM PRINTING OF THE ITEMIZED BILLS YOU HAVE ATTACHED TO THIS CLAIM FORM PRINTING OF THE ITEMIZED BILLS YOU HAVE ATTACHED TO THIS CLAIM FORM PRINTING OF THE ITEMIZED BILLS YOU HAVE ATTACHED TO THIS CLAIM FORM PRINTING OF THE ITEMIZED BILLS YOU HAVE ATTACHED TO THIS CLAIM FORM PRINTING OF THE ITEMIZED BILLS YOU HAVE ATTACHED TO THIS CLAIM FORM PRINTING OF THE ITEMIZED BILLS YOU HAVE ATTACHED TO THIS CLAIM FORM PRINTING OF THE ITEMIZED BILLS	4. NAME OF PROVIDER WHO RENDERS	ED THE SERVICE AN	ND PHONE NUMB	ER									
NAME PHONE NO. PLEASE COMPLETE THE FOLLOWING AS A SUMMARY OF THE ITEMIZED BILLS YOU HAVE ATTACHED TO THIS CLAIM FORM 7. DATE OF SERVICE 19, CHARGE FOR SERVICE 20. BRIEFLY DESCRIBE THE SERVICE(S) YOU RECEIVED 20. BRIEFLY DESCRIBE THE SERVICE(S) YOU RECEIVED 21. TOTAL CHARGES FOR WHICH YOU ARE REQUESTING CONSIDERATION OF PAYMENT? 22. TOTAL CHARGES FOR WHICH YOU ARE REQUESTING CONSIDERATION STATE OF PAYMENT? 3. PLACE OF SERVICE OP - OUTPATIENT HOSPITAL IP - INPATIENT HOSPITAL L- LAB DF PAYMENT? 3. PLACE OF SERVICE OP - OUTPATIENT HOSPITAL IP - INPATIENT HOSPITAL L- LAB DF PAYMENT?	NAME		PHONE NO.					UTPATIENT C	OR INPATIENT I	HOSPITAL, PROV	IDE		
PLEASE COMPLETE THE FOLLOWING AS A SUMMARY OF THE ITEMIZED BILLS YOU HAVE ATTACHED TO THIS CLAIM FORM 7. DATE OF SERVICE 18. PLACE OF SERVICE 20. BRIEFLY DESCRIBE THE SERVICE(S) YOU RECEIVED 20. BRIEFLY DESCRIBE THE SERVICE(S) YOU RECEIVED 21. TOTAL CHARGES FOR WHICH YOU ARE REQUESTING CONSIDERATION OF PAYMENT? 22. TOTAL CHARGES FOR WHICH YOU ARE REQUESTING CONSIDERATION STATE AND	6. IF WE HAVE QUESTIONS, WHO MAY	WE CONTACT?			NAM	E OF HOSPITA	L FACILII Y						
7. DATE OF SERVICE 18. PLACE OF SERVICE 20. BRIEFLY DESCRIBE THE SERVICE(S) YOU RECEIVED 20. BRIEFLY DESCRIBE THE SERVICE(S) YOU RECEIVED 21. TOTAL CHARGES FOR WHICH YOU ARE REQUESTING CONSIDERATION OF PAYMENT? 3. PLACE OF SERVICE O - OFFICE OP - OUTPATIENT HOSPITAL IP - INPATIENT HOSPITAL L - LAB OF PAYMENT?	NAME		PHONE NO.										
SERVICE SERVICE* SERVICE 20. BRIEFLY DESCRIBE THE SERVICE(S) YOU RECEIVED 20. BRIEFLY DESCRIBE THE SERVICE(S) YOU RECEIVED 21. TOTAL CHARGES FOR WHICH YOU ARE REQUESTING CONSIDERATION OF PAYMENT? 22. TOTAL CHARGES FOR WHICH YOU ARE REQUESTING CONSIDERATION OF PAYMENT? 23. TOTAL CHARGES FOR WHICH YOU ARE REQUESTING GONSIDERATION OF PAYMENT? 24. TOTAL CHARGES FOR WHICH YOU ARE REQUESTING GONSIDERATION OF PAYMENT? 25. TOTAL CHARGES FOR WHICH YOU ARE REQUESTING GONSIDERATION OF PAYMENT? 26. TOTAL CHARGES FOR WHICH YOU ARE REQUESTING GONSIDERATION OF PAYMENT? 27. TOTAL CHARGES FOR WHICH YOU ARE REQUESTING GONSIDERATION OF PAYMENT? 28. TOTAL CHARGES FOR WHICH YOU ARE REQUESTING GONSIDERATION OF PAYMENT? 29. PLACE OF SERVICE OP - OUTPATIENT HOSPITAL IP - INPATIENT HOSPITAL L - LAB OF PAYMENT?	PLEASE COMPL	ETE THE FOL	LOWING AS	A SUMMARY O	F THE ITE	MIZED BIL	LS YOU I	HAVE ATT	ACHED TO	THIS CLAIF	M FORM		
ARE REQUESTING CONSIDERATION O - OFFICE OP - OUTPATIENT HOSPITAL IP - INPATIENT HOSPITAL L - LAB OF PAYMENT? H - HOME NH - NURSING HOME P - PHARMACY				20. BRIEFLY DESCRIBE THE SERVICE(S) YOU RECEIVED						D			
ARE REQUESTING CONSIDERATION O - OFFICE OP - OUTPATIENT HOSPITAL IP - INPATIENT HOSPITAL L - LAB OF PAYMENT? B H - HOME NH - NURSING HOME P - PHARMACY													
ARE REQUESTING CONSIDERATION O - OFFICE OP - OUTPATIENT HOSPITAL IP - INPATIENT HOSPITAL L - LAB OF PAYMENT? H - HOME NH - NURSING HOME P - PHARMACY													
ARE REQUESTING CONSIDERATION O - OFFICE OP - OUTPATIENT HOSPITAL IP - INPATIENT HOSPITAL L - LAB OF PAYMENT? H - HOME NH - NURSING HOME P - PHARMACY													
ARE REQUESTING CONSIDERATION O - OFFICE OP - OUTPATIENT HOSPITAL IP - INPATIENT HOSPITAL L - LAB OF PAYMENT? H - HOME NH - NURSING HOME P - PHARMACY													
ARE REQUESTING CONSIDERATION O - OFFICE OP - OUTPATIENT HOSPITAL IP - INPATIENT HOSPITAL L - LAB OF PAYMENT? H - HOME NH - NURSING HOME P - PHARMACY													
	ARE REQUESTING CONSIDERATION	8		O - OFFICE								L - LAB	
MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM.	22. I CERTIFY TO THE ACCURA	ACY AND COM			TION REPO	ORTED BY	ME ON TH	HIS FORM	AND AUTH	ORIZE THE I	RELEASE	OF ANY	

DATE

FULL SIGNATURE AND DATE
REQUIRED ON EACH FORM
INCOMPLETE FORMS MAY DELAY PROCESSING. PLEASE ENSURE ALL FIELDS ARE ANSWERED.

SIGNATURE

SUBSCRIBER CLAIM FILING INFORMATION (HOW TO FILE)

Be sure to ask your provider of care if he/she will file a claim with Prominence Health Plan. Please submit statements only if the provider does not bill us directly. To receive benefits for services by a provider who does not bill us directly, complete the Claim Form, attach itemized bills, proof of payment (if applicable) and mail to:

Prominence Health Plan Claims Department 1510 Meadow Wood Lane Reno, NV 89502

Keep a duplicate copy of your itemized bills and proof of payment as they will not be returned to you. <u>This claim</u> <u>may be returned to you if all required information is not present.</u>

CLAIM FILING INSTRUCTIONS

(Corresponds to numbered items on Claim Form)

A separate Claim Form for each family member and each provider of care must be submitted.

ITEM NO.

- 1–8 Please complete all blocks. All fields required.
- 9-12a Appropriate responses to these questions will ensure expedient and proper handling of your claim.
- 13 Statement of why these services were required.
- Indicate the name of the physician, hospital or other institutional facility who has billed for services provided to the patient. **Only one provider per form.**
- If laboratory or radiology services are being billed by a professional provider, and the place of service was inpatient or outpatient hospital, indicate the name of the hospital.
- Name and telephone number; whoever can help us if additional information is required.
- 17 Use a separate line for each date of service and receipt.
- Write the appropriate code to indicate the place of service by using the legend below this section.
- 19 Indicate the total charge for each service.
- 20 Briefly indicate the type of service, i.e. lab, X-ray, surgery, therapy, cast, stitches, etc.
- This amount represents the total of all charges to be considered for benefit.
- Your signature attests to the accuracy and completeness of all information on the claim and the attachments and authorizes the release of your medical records by the provider to our office if necessary.

REQUIRED INFORMATION

Itemized Bills: Summarizing the services may help us better understand the attachments if they are not clear. The attached itemized bills must include the provider name, patient's name, date of service, detailed description of service, and amount charged for that service. These must be valid documents from the provider.

HELPFUL HINTS

- If you have questions or need assistance, contact Prominence Health Plan Customer Service at 800-863-7515 (HMO) or 800-433-3077 (PPO).
- To reduce the possibility of small billings getting lost or separated, please attach these to an 8 1/2x11 piece of paper.
- We encourage you to file claims within 90 days of the service date. Please refer to your Evidence of Coverage (EOC) (HMO) or Certificate of Coverage (COC) (PPO) for specific timely filing limitations.
- File only if the provider has not.

Important: If the services for this claim were provided by a participating physician or hospital, the benefit payment will go to the provider.

A complete description of your benefits, as well as limitations and exclusions applicable thereto, is available in the EOC and COC. Final interpretation of any and all provisions of the program is governed by the EOC and COC.