CAPROCK HEALTH GROUP
A Healthcare Services Organization

FORMERLY

MAXOR® ADMINISTRATIVE SERVICES

Medical Claim Form

Complete and submit to Caprock HealthPlans

Mail Claim to:
P.O. Box 15050
Amarillo, TX 79105

IMPORTANT: Please have your doctor or supplier of medical services complete the reverse of this form or attach a fully iternized bill. A diagnosis must be shown on the bill.

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EMPLOYEE INFORMATION:		**GROUP NAME, #:**		
Name (last, first, initial)		Sex / Employer Name		
Home Address		Identification Number	Birthdate	Group Number
City	State	Zip Code	Work Telephone ( )	Home Telephone ( )

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PATIENT INFORMATION:

The patient is: ☐ **EMPLOYEE** ☐ **SPOUSE** (complete spouse information) ☐ **DEPENDENT CHILD** (complete spouse and child information)

Spouse's Name (last, first, initial)	Sex	Child's Name (last, first, initial)	Sex
Spouse's Birthdate / Spouse's SSN		Child's Birthdate	Child's SSN
Spouse's Employer			
Spouse's Employers' Address			

3

DOES ANYONE HAVE ANY OTHER COVERAGE?

☐ **YES** (then complete) ☐ **NO** (go to next section)

NAME OF POLICYHOLDER:

Name of Other Health Insurance Carrier or Plan	Address	City	State	Zip Code
Other Insurance Carrier's or Plan's Telephone No.	Type of Coverage ☐**GROUP** ☐**INDIVIDUAL**	Group Number	Contract or Policy Number	
Spouse's Employer	If child is over age 19 and full-time student, complete: Name of School:			
Spouse's Employer's Address	School Address:			

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ABOUT THIS CLAIM

☐INJURY ☐ILLNESS
Date and time of accident:

Describe injury, when and how it happened or nature of illness:

Was injury the result of auto accident? ☐ YES ☐ NO

If auto insurance involved, please provide: Policy No. Name of Insurance Company Address (City, State, ZIP Code)

Did you or the patient receive, seek, or will be seeking monetory recovery for accident/injury? ☐ YES ☐ NO

Work related injury? ☐ YES ☐ NO

If injury is work related, please contact your employer for proper instructions regarding this claim.

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EMPLOYEE'S (or adult dependent's) SIGNATURE REQUIRED - Authorization to release information

The statements above are true and correct to the best of my knowledge. I authorize any provider of services to furnish any information requested to the Benefit Administrator. I also authorize the Benefit Administrator to release of obtain from any organization or person information that may be necessary to determine benefits payable under the Benefit Plan. A photostatic copy of this authorization shall be considered as effective and valid as the original. For any payment that exceeds the amounts payable under the Benefit Plan, I agree to reimburse the plan in a lump sum payment or by an automatic reduction in the amount of future benefits that would otherwise be payable.

Signature _____ Date _____

Caprock HealthPlans

Health Insurance Claim Form

1. MEDICARE MEDICAID CHAMPUS CHAPVA GROUP HEALTH PLAN FECA BLK LUNG OTHER ☐ *(Medicare #)* ☐ *(Medicaid #)* ☐ *(Sponsor's SSN)* ☐ *(VA File #)* ☐ *(SSN or ID)* ☐ *(SSN)* ☐ *(ID)*		1a. Insured's ID Number (For Program in Item 1)
2. Patient's Name (Last Name, First Name, Middle Initial)	3. Patient's Birth Date Sex ☐ M ☐ F	4. Insured's Name (Last Name, First Name, Middle Initial)
5. Patient's Address (No., Street)	6. Patient Relationship to Insured Self ☐ Spouse ☐ Child ☐ Other ☐	7. Insured's Address (No., Street)
City / State	8. Patient Status Single ☐ Married ☐ Other ☐ Employed ☐ Full-time ☐ Part-time ☐ student student	City / State
Zip Code / Telephone (Include Area Code) ( )		Zip Code / Telephone (Include Area Code) ( )
9. Other Insured's Name (Last Name, First Name, Middle Initial)	10. Is Patient's Condition Related To: a.Employment? (Current or Previous) ☐ YES ☐ NO	11. Insured's Policy Group or Feca Number
a. Other Insured's Policy or Group Number	b. Auto Accident? Place (State) ☐ YES ☐ NO |_____|	a. Insured's Date of Birth Sex
b. Other Insured's Date of Birth Sex ☐ M ☐ F	c. Other Accident? ☐ YES ☐ NO	b. Employer's Name or School Name
c. Employer's Name or School Name		c. Insurance Plan Name or Program Name
d. Insurance Plan Name or Program Name	10d. Reserved For Local Use	d. Is There Another Health Benefit Plan? ☐ **YES** ☐ **NO** **If yes**, return to and complete item 9a-d.
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. **SIGNED** **DATE**		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____
14. Date of Current: Illness (First symptom) OR Injury (Accident) OR Pregnancy (LMP)	15. If Patient Has Had Same Or Similar Illness. Give First Date:	16. Dates Patient Unable to Work In Current Occupation From: To:
17. Name of Referring Physician or Other Source	17a. ID Number of Referring Physician	18. Hospitalization Dates Related To Current Services From: To:
19. Reserved For Local Use		20. Outside Lab? $ Charges ☐ YES ☐ NO
21. Diagnosis or Nature Of Illness Or Injury. (Relate Items 1, 2, 3, or 4 to Item 24E By Line) 1. |_____ . ____ 3. |_____ . ____ 2. |_____ . ____ 4. |_____ . ____		22. Medicaid Resubmission Code Original Ref. No. 23. Prior Authorization Number

24. A Date(s) of Service From MM DD YY To MM DD YY	B Place of Service	C Type of Service	D Procedures, Services, Or Supplies (Explain Unusual Circumstances) CPT/HCPCS | Modifier	E Diagnosis Code	F $ Charges	G Days or Units	H EPSDT Family Plan	I EMG	J COB	K Reserved for Local Use
1											
2											
3											
4											
5											
6											

25. Federal Tax I.D. Number SIN ☐ EIN ☐	26. Patient's Account No.	27. Accept Assignment? (For govt. claims, see back) ☐ YES ☐ NO	28. Total Charge $ |	28. Amount Paid $ | 30. Balance Due $ |
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED _____ DATE____	32. Name of Address of Facility Where Services Were Rendered (If other than home or office)		33. Physician's, Supplier's Billing Name, Address, Zip Code & Phone #: PIN#_____ | GRP#_____	

Please Print Or Type