



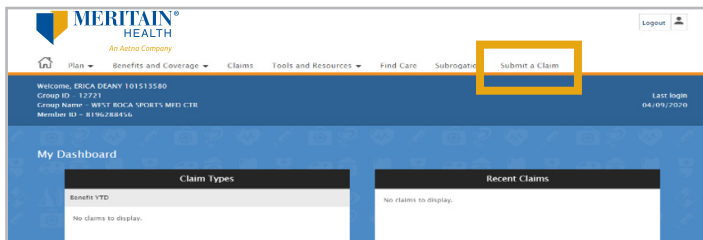
# How to Submit a Claim

## What you'll need to submit a claim

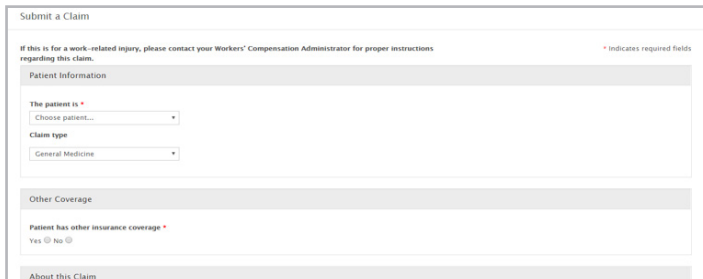
- Patient's information
- Provider's information including name, address where services were provided and Tax Identification Number (TIN)
- Detailed invoice including CPT code or description of services and diagnosis code

## How to submit a claim online

1. After logging in to your Meritain Health® account, click on the *Submit a Claim* link at the top of the page. Claims can be submitted for any covered member.

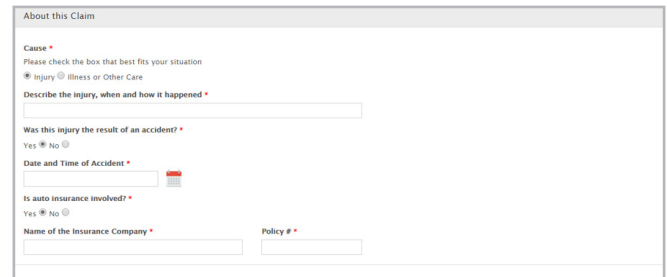


2. Select *General Medicine* under the *Claim Type* drop-down. Select *Illness or Other Care* or *Injury*, depending on your claim. You will be guided to answer additional questions in order to complete the claim.



3. Next, you'll be asked to enter information about your provider.

- If you click *Yes* for a detailed invoice, there will be no additional questions and you'll be instructed to add the required documents. You can take a picture of your documentation and attach it.
- If you click *No* for a detailed invoice, you'll then be guided through additional required questions, starting with hospitalization.
- You can then electronically sign and submit the claim.



4. If there is no detailed invoice from the provider, you must complete the *Additional Information Page* to submit the claim.
- Additional information includes diagnosis code, procedure code, service date, place of service and charges.

Supporting Information

Do you have a detailed invoice from the provider with the Procedure and Diagnosis codes, Provider Tax ID, etc.?

Yes  No

Supporting Documents

Attach a detailed copy of your provider's bill for accurate and timely reimbursement \*

NOTE:

- Do not submit a request for reimbursement for more than one patient at a time.
- Do not submit a request for multiple providers in one claim.
- Each claim can include up to four attachments (pdfs or image files), with a maximum of 6 MB per attachment.

Payment Instructions:

Select a payment option below. \*

I authorize payment of benefits to the person who submitted the claim.

I authorize payment of benefits to the doctor or supplier of services listed here.

EMPLOYEE'S (or adult dependent's) SIGNATURE REQUIRED

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 Benefits Administrator. I also authorize the Benefits Administrator to release or 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

5. Lastly, you'll specify who will receive payment—you or the provider. If you select the provider, you'll need to provide the name and Tax Identification Number (TIN) of the provider to receive payment.
- If selecting *Pay To Member*, proof of payment will need to be submitted as part of your documentation.

About this Claim

Cause \*

Please check the box that best fits your situation

Injury  Illness or Other Care

Describe the injury, when and how it happened \*

Was this injury the result of an accident? \*

Yes  No

Date and Time of Accident \*

Is auto insurance involved? \*

Yes  No

Name of the Insurance Company \*

Policy # \*

**Questions? Just give us a call at the number on the back of your ID card.**