Claim Submission Cover Form

Claims Department
PO Box 11088
Charlotte, NC 28220-1088

This cover form **MUST be submitted along with** a receipt showing paid and a detailed statement/bill from the provider which includes:

1) The Tax ID Number, complete address, name and phone number for the provider.

2) The complete and accurate diagnosis coding (ICD-10), Current Procedural Terminology (CPT) code(s) or Dental Procedural Terminology (DPT) code(s) for all charges to be considered for coverage.

Please mail to the address listed on the Member Identification Card – ATTN: CLAIMS

EMPLOYEE NAME:		GROUP NAME:		GROUP NUMBER:	DATE OF HIRE:
PATIENT NAME:		DATE OF BIRTH:		RELATIONSHIP TO EMPLOYEE: ☐ Spouse ☐ Child	
EMPLOYEE ADDRESS:		CITY:		STATE:	ZIP CODE:
ID # ON ID CARD:	BEST CALLBACK NUMBER FOR EMPLOYEE:		DATE EMPLOYEE LAST ACTIVELY AT WORK:		
IS THE PATIENT COVERED BY ANY OTHER INSURANCE COVERAGE? (TO INCLUDE MEDICAID, MEDICARE, AND TRICARE) ☐ Yes ☐ No If yes, please give complete information about the coverage in the space below.					
NAME OF OTHER INSURANCE COMPANY:					
ADDRESS:		CITY:		STATE:	ZIPCODE:
NAME OF EMPLOYER, GROUP, OR SCHOOL PROVIDING THE PLAN:				POLICY # OR CERTIFICATE #:	
NAMES OF ALL PERSONS COVERED BY OTHER INSURANCE:					

Additional information or signed responses to certain information requests may be required. Notification of such requests will be made through standard USPS delivery to the address listed for the policyholder.

Please allow 30 days for processing.

To contact Member Services, please call 800-446-5439 Monday–Friday 8am-7pm ET

This form can also be e-mailed along with your detailed statement to askconnect@healthgram.com.