North Carolina
State Health Plan
Teachers' and State Employees' Comprehensive Major Medical Plan
and North Carolina Health Choice

MAIL TO:
CLAIMS PROCESSING CONTRACTOR
PO BOX 30025
DURHAM NC 27702-3025

MEMBER SUBMITTED MEDICAL CLAIM FORM

GENERAL INFORMATION: Type or print. Complete a separate claim for each patient. Attach itemized receipts. Do not staple items. Be sure to sign the form. Do not submit a claim if the doctor or hospital is also filing a claim for the same services. PRESCRIPTION DRUG CLAIMS MUST BE FILED WITH MEDCO; PLEASE CONSULT YOUR PHARMACIST. Thank You.

SECTION I: PATIENT INFORMATION

1. YOUR MEMBER ID MUST BE COMPLETE IN ORDER TO PROCESS YOUR CLAIM.

☐ PLEASE CHECK IF NC HEALTH CHOICE POLICY.

2. PATIENT'S NAME *(LAST NAME)* *(FIRST NAME)* *(MIDDLE INITIAL)*

3. PATIENT'S DATE OF BIRTH MONTH / DAY / YEAR

4. PATIENT'S SEX ☐ MALE ☐ FEMALE

5. PATIENT'S RELATIONSHIP TO MEMBER ☐ SELF ☐ SPOUSE ☐ CHILD

6. DOES THE PATIENT HAVE OTHER HEALTH INSURANCE COVERAGE? ☐ YES ☐ NO *(IF NO, MOVE TO BOX NO. 7)*

A. NAME OF OTHER POLICY HOLDER: _____

B. NAME OF OTHER EMPLOYER: _____

C. POLICY OR OTHER CERTIFICATE NUMBER: _____

D. NAME OF OTHER INSURANCE COMPANY: _____

7. WAS CONDITION RELATED TO:

A. PATIENT'S EMPLOYMENT ☐ YES ☐ NO

B. AUTO ACCIDENT ☐ YES ☐ NO

C. OTHER ACCIDENT ☐ YES ☐ NO

D. DATE OF ONSET: _____

SECTION II: MEMBER INFORMATION AND STATEMENT

8. MEMBER'S NAME *(LAST, FIRST, MIDDLE INITIAL)*

STREET ADDRESS OR ROUTE AND BOX NUMBER

CITY STATE ZIP CODE

TELEPHONE *(DAYTIME)* *(EVENING)*

9. PLEASE GIVE A DIAGNOSIS FOR EACH SERVICE SUBMITTED.

I CERTIFY THAT THE INFORMATION ON THIS FORM IS CORRECT AND THE EXPENSES INCURRED WERE NECESSARY FOR THE TREATMENT OF THE CONDITIONS INDICATED.

MEMBER'S SIGNATURE: _____ **DATE CLAIM SUBMITTED:** _____

PLEASE ATTACH COPY OF POWER OF ATTORNEY DOCUMENT IF NOT ALREADY ON FILE.

SECTION III: SERVICES NOT FILED BY DOCTOR OR HOSPITAL

(OFFICE VISITS, HOSPITAL VISITS, PHYSICAL THERAPY, AMBULANCE, DURABLE MEDICAL EQUIPMENT, MEDICAL SUPPLIES, ETC.

DATE OF SERVICE *(MO/DAY/YR)*	TYPE OF SERVICE *(DESCRIBE BRIEFLY)* WE CANNOT ACCEPT CANCELLED CHECKS, "PAID ON ACCOUNT" ENTRIES, "BALANCE DUE" ENTRIES, OR CASH REGISTER RECEIPTS AS PROOF OF SERVICES	CHARGE
07/01/05	EXAMPLE: Office Visit	$ 25. 00
07/01/05	Chest X-Ray	$ 30. 00

PLEASE CONTINUE ON THE REVERSE SIDE.

EACH SERVICE CHARGE MUST BE LISTED SEPARATELY. PLEASE ATTACH ALL ITEMIZED RECEIPTS.

DATE OF SERVICE *(MO/DAY/YR)*	TYPE OF SERVICE *(DESCRIBE BRIEFLY)* WE CANNOT ACCEPT CANCELLED CHECKS, "PAID ON ACCOUNT" ENTRIES, "BALANCE DUE" ENTRIES, OR CASH REGISTER RECEIPTS AS PROOF OF SERVICES	CHARGE	

SECTION IV: PRIVATE DUTY NURSING

(Please attach receipts. Ask doctor to enter the reason for nursing care and sign form below.)

DATE OF SERVICE FROM *(MO/DAY/YEAR)*	DATE OF SERVICE THROUGH *(MO/DAY/YEAR)*	NAME OF NURSE	CHECK TYPE RN	CHECK TYPE LPN	LICENSE NUMBER	HOURS	CHARGE	
07/01/05	07/01/05	EXAMPLE: Ms. Jane E. Smith			98765	16	$ 160.	00

REASON FOR PRIVATE DUTY NURSING: _____

_____ DOCTOR'S SIGNATURE: _____

EACH SERVICE CHARGE MUST BE LISTED SEPARATELY. PLEASE ATTACH ALL RECEIPTS.

Mail this Medical Claim Form directly to:

CLAIMS PROCESSING CONTRACTOR
PO BOX 30025 • DURHAM NC 27702-3025

If the patient is covered under any other health insurance, a copy of the Explanation of Benefits from the other health insurance carrier showing how much was paid for these services must be attached.

IF YOU HAVE QUESTIONS, CALL: (800) 422-4658 • (919) 489-8389