EthiCare ADVISORS

Medical Claims Settlement Submission Cover Sheet

Download this form at HTTP://www.claimsubmissionform.com

Client Information:

Date of Request: ___ /___ /___

Client Name: _____ Tel: (___) ___ - ____

Name of Person Referring Claim: _____

E-mail: _____

Reinsurer / Stop Loss: _____ MGU: _____

Group / Plan Name: _____ Group/Policy No.: _____

Effective Date ___ /___ /___ Contract Type: _____ Specific Deductible: $ _____

Patient Information:

Patient Name: _____ ID No.: _____

Facility / Provider: _____ Tax ID: _____

DOS: From ___ /___ /___ To ___ /___ /___ Billed Charges: $ _____

Is there some type of Network Discount? ☐ Yes ☐ No Network: _____

Type of Network Discount? ☐ % of Billed Charges ☐ Per Diem ☐ Case Rate ☐ DRG ☐ Unknown

Discount Amount: $ _____ Discount %: _____ Discount Expires on: ___ /___ /___

Please provide this information prior to claim submission:

Patient Liability: $ _____ Deductible / Out of Pocket owed: $ _____

If we obtain a discount, can benefits be treated at the in-network level of benefits? Yes ☐ No ☐

If yes, at what percentage are benefits payable? _____ Statutory Pmt Deadline: ___ /___ /___

When are checks cut for this group? _____

Has any payment been made on this bill? Yes ☐ No ☐ If yes, amount paid $ _____

Comments / Special Instructions / Benefit Limitations:

_____

_____

_____

Services Requested:

☐ Pre-Screen & Call to Discuss ☐ Sign-Off ☐ Bill Review/Audit ☐ U&C Review

Special Claim Handling:

High-Dollar: ☐ Facility ☐ Ancillary ☐ Professional ☐ Dialysis

Submit the completed form with provider bills to:

claims@ethicareadvisors.com or (866) 662-4121 *(fax)*