Farm Bureau Advantage HMO
P.O. Box 300, Columbia, TN 38402-0300
Phone 1-833-999-0103
fbhealthplans/medicare-advantage.com

MEDICARE ADVANTAGE SUBSCRIBER HEALTH CARE CLAIM FORM

-CONFIDENTIAL-

Complete one form for each claim submitted

PLEASE TYPE OR PRINT INFORMATION

SECTION 1 - PATIENT INFORMATION

Patient's Name as shown on Member ID Card *(Last, First, Middle)*

Patient's Member ID # and Group # exactly as it is shown on the Member ID card:

Date of Birth *(mm/dd/yyyy)*	◯ Male ◯ Female

Street address (or P.O. Box - include apartment number)

City	State	Zip code

Phone number

SECTION 2 - INFORMATION ABOUT SERVICES FURNISHED

FOR ALL CLAIMS including Influenza and Pneumococcal Vaccinations, describe the illness or injury for which you received treatment below:

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SECTION 3 - ATTACH SUPPORTING DOCUMENTS

Attach all supporting documentation to the form including an itemized bill with the following information:

- Date of service
- Place of service
- Description of illness or injury
- Description of each surgical or medical service or supply furnished
- Charge for each service
- The doctor's or supplier's name and address
- The provider or supplier's National Provider Identifier (NPI) If known_____
- Referring Provider name
- Referring Provider Address
- Referring Providers National Provider Identifier (NPI) If known_____

IMPORTANT: If the itemized bill is from:

- A Clinical laboratory for ordered tests
- An independent diagnostic imaging center for ordered imaging procedures
- A supplier of Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) for ordered DMEPOS. The ordering & referring providers legal name **MUST** be included on the itemized bill.
- Please also include the ordering & referring providers National Provider Identifier (NPI) if known.

Was the condition related to:

○ Yes ○ No Employment

○ Yes ○ No Auto Accident

○ Yes ○ No Treatment for chronic dialysis or kidney transplant

○ Yes ○ No Other Accident

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SECTION 4 – AUTHORIZATION COMPLETE FOR ALL CLAIMS

Pay benefits for this claim: ☐ **To me, the member**
☐ **Directly to the provider of service (doctor, hospital, clinic, etc.)**

1. I hereby authorize any doctor, hospital, clinic, provider of health care, insurance or reinsurance company, or any other person or firm to release any information requested with respect to this claim and any attached bills.
2. I declare that the information on this claim form and any attached bills is true, complete and correct.
3. I understand it is a crime to knowingly provide false, incomplete or misleading information to Farm Bureau Health Plans for the purpose of defrauding the company. Penalties may include imprisonment, fines and denial of insurance benefits.

_____ _____
Signature ***Date***

SECTION 5 – INSTRUCTIONS FOR FILING CLAIMS

Members: Use the following procedure when your provider does not file a claim. This information applies to any doctor, hospital, clinic or provider of health care.

NOTE: If you have questions completing this form, please call 833-999-0103

1. Ask the provider for a claim form you can use to file yourself.
2. If the provider cannot give you a claim form, you may use this claim form by following the directions below.
   a. Fill out all the information on the front page of this form.
      - Note the authorization instructions for payment and indicate if the claim should be paid to you directly or to the provider of the service.
      - Sign and date the form.

b. Attach to the claim form all itemized bills related to this claim. The physician or facility where the service was rendered should provide you with such bills. The itemized bills should include:

- the name and address of the physician or other provider of service;
- the name of the patient;
- the date of each service;
- the procedure code(s) AND diagnosis code(s) for each service (your provider can supply these codes);
- the amount of charge for each service (cancelled checks, cash register receipts, money orders, credit card vouchers, personal list of services or bills only stating "balance forward" are not acceptable substitutes for itemized bills) and
- proof of payment which can include cancelled checks, cash register receipts, money orders, credit card vouchers, etc.

Note: For your records, please keep copies of all information sent to Farm Bureau Advantage

3. Mail the completed claim form and attachments to:

   Farm Bureau Advantage HMO
   P.O. Box 300
   Columbia, TN 38402-0300

4. After your claim is processed, Farm Bureau Advantage will send you an Explanation of Benefits (EOB) and a check if you are due payment.