UCLA Health | Medicare ADVANTAGE PLAN

Medical Claim Form

Save this PDF to your computer prior to filling out the form.

Use your provider's itemized bill(s) to complete the below form. Please submit a separate claim form for each provider visited. Your cooperation in fully completing this form and providing necessary documentation will help ensure quick and accurate processing.

Section 1: Subscriber Information

Last Name:	**First Name:**	**M.I.:**
ID Number *(Found on your UCLA Health Medicare Advantage Plan ID card):*	**Date of Birth:** __/__/____	Sex: ☐ Male ☐ Female

Section 2: Patient Information *(If different from subscriber)*

Patient Last Name:	**Patient First Name:**	**M.I.:**	**Sex:** ☐ Male ☐ Female
Date of Birth: ___/_____/_____	**Relationship to Subscriber:**		

Section 3: Coordination of Benefits - Other Insurance

Does the patient have other health insurance coverage? ☐ Yes ☐ No	**Subscriber Name:**	
Name of other insurance company:	**Group No.**	**Policy No.**

Section 4: Medical Information

Health care services: Use this section to report any covered health service that have not already been reported to UCLA Health Medicare Advantage Plan by the provider of service (the physician, clinic, ambulance company, private duty nurse, etc.). Where was the service rendered?

☐ Physician office ☐ Hospital Outpatient ☐ Hospital Inpatient ☐ Ambulance
☐ Medical equipment supplier ☐ Pharmacy ☐ Laboratory ☐ Other

Was this medical expense the result of an accident? ..... ☐ Yes ☐ No

When did this injury or accident occur? (MM/DD/YYYY) _____/_____/_____

Was this service or injury job related? ..... ☐ Yes ☐ No

Date of Service	**Diagnosis Code**	**Procedure Code (CPT)**	**Provider Tax ID**	**Amount**
__/__/____				**$**
__/__/____				**$**
__/__/____				**$**
			Total	**$**

Each claim form must be submitted with an itemized bill. Each itemized bill must include:

- Name and address of the provider (doctor, hospital, lab, etc.)
- Diagnosis code
- Procedure code
- Date of service
- Amount charged per service
- Name of patient
- Service provided
- Tax ID

I certify that, to the best of my knowledge, the information on this Medical Claim Form is true and correct. I authorize the release of my medical information as necessary to process this claim.

Signature: **X**	Printed name:	Date: (MM/DD/YYYY)

Select 'Print' and then mail your completed form and itemized bill to: **UCLA Health Medicare Advantage Plan, Attn: Claims Department, P.O. Box 211622, Eagan, MN 55121-3622**. You can also print this form and fax it to us at 1-424-305-1035. Please fax the itemized bill along with this form. If you have any questions, you can call Member Services at 1-833-627-8252 (**TTY Users**: 711).