



Member Claim Submission Form

P.O. Box 948 • Frederick, MD 21705-0948

MEMBER INFORMATION

Member's Social Security Number		Member's Member Number	
Member's Name (Last)	(First)	(M.I.)	Subscriber's Name (Last) (First) (M.I.)
Member's Address if Different than Subscriber's		Subscriber Address	
Member's Date of Birth	Member's Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Member's Relationship to Subscriber <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent Child <input type="checkbox"/> Other	Telephone Number

NATURE OF ILLNESS/ACCIDENT

Nature of Illness or Injury (state when, where and how it occurred)	Did you have a referral for these services? Yes No
Is illness/accident related to employment? Yes No	Auto accident? Yes No
	Other accident? Yes No

OTHER HEALTH INSURANCE INFORMATION

Please complete if the member is covered by additional health care coverage through an employer, a group such as a professional organization, or any other health plan.

Name and Address of Carrier (please include street address, city, state and ZIP)	Policy Number
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PROOF OF PAYMENT

Member will only be reimbursed if acceptable proof of payment is submitted with claim.

For Members: Acceptable proof of payment includes cancelled checks or receipts from the provider(s) of service.
 For Hospitals: All hospital submissions must be itemized on a UB92 Form with proof of payment (Box 54) completed.
 For Physicians: All physician submissions must be itemized on a HCFA/CMS 1500 Form with proof of payment (Box 29) completed.

Note: A cancelled check would show proof of payment, but is not in itself sufficient. An itemized bill should also be submitted and must have the member name and member number, provider name and address, description of services (CPT Codes), date of service, amount of charge and diagnosis.

ASSIGNMENT OF BENEFITS (If signed, payment will be made directly to provider)

I hereby authorize payment directly to the provider of services. All benefits are payable after applicable copayments according to the description in the member's Evidence of Coverage. I understand that I am financially responsible to the provider for charges not covered by this assignment. However, if a claim is not submitted with proof of payment, benefit payment will be made directly to the provider of services. Payment for services rendered by a non-participating provider will be sent directly to the member when the group is subject to non-assignment policies as established by MAMSI.

Signed _____ Date _____

For Physicians: All physician submissions must be itemized on a HCFA/CMS 1500 Form with Box 12 completed.
 For Hospitals: All hospital submissions must be itemized on a UB92 Form with Box 53 indicating "Y" for assignment.

AUTHORIZATION

I certify that the information I have given is accurate to the best of my knowledge and that I, as the Subscriber, am claiming benefits only for the charges incurred by the member identified above. I authorize the release of any medical information necessary to process this claim.

Subscriber Signature _____ Date _____

Member Signature _____ Date _____

HOW TO FILE A CLAIM

**EXTRA POSTAGE
MAY BE REQUIRED**

Instructions

Assemble all itemized health care bills; a HCFA/CMS 1500 claim form is preferred (make sure you send the original copy of the bills and retain a copy for yourself).

Separate your bills by family member - you will need a different claim form for each member.

Note: if you have other coverage you must fill out the "Other Health Insurance Information" section and provide copies of any explanation of benefits that apply to the claims being submitted.

The ORIGINAL itemized bill for each health care professional must be included and must contain all of the following information:

- Letterhead indicating the person or organization providing the service, their address and provider tax identification number.
- The name of the patient receiving the service.
- The service date.
- The charges for each service.

For Behavioral Health Services (e.g. mental health claims), please make sure that bills include the session length, type and provider's professional status.



Return completed claim form and original bills to: MAMSI, P.O. BOX 948, Frederick, MD 21705-0948.

When a member seeks care from a participating provider, payment will be sent to the participating provider.

All claims must be submitted within 180 days of service(s) date.

PLEASE STAPLE YOUR CLAIMS
TO YOUR CLAIM FORM

POST OFFICE
WILL NOT
DELIVER
WITHOUT
PROPER
POSTAGE

MAMSI
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FREDERICK, MD 21705-0948