Member Claim Form

☐ **Dental Services**
☐ **All Other Services**
This form may not be used for pharmacy claims.

A. Member Information

1a. Member ID		
2a. Health Plan		
3a. Phone#:		
4a. Last Name:	5a. First Name:	6a. MI:
7a. Date of Birth: xx/xx/xxxx		
8a. Home Address:		
9a. City:	10a. State:	11a. Zip Code:
12a. Sex	☐ M	☐ F
13a. School Name:		

B. Patient Information (If different from above):

1b. Patient's Member ID		
2b. Last Name:	3b. First Name:	4b. MI:
5b. Date of Birth: xx/xx/xxxx		
6b. Home Address:		
7b. City:	8b. State:	9b. Zip Code:
10b. Sex	☐ M	☐ F
11b. Relationship to Member:		
12b: Full Time Student:	☐ Yes	☐ No
13b: School Name		

C. Accident Information (If applicable):

1c. Accident

☐ Work	☐ Auto	☐ Other

2c. Date Accident Occurred: xx/xx/xxxx

3c. How did the accident occur?

D. Other Insurance

1d. Is the patient covered by another insurance plan?

☐ Yes	☐ No

If yes, please complete the following:

2d. Name of Person Carrying Other Insurance:

3d. Date of Birth: xx/xx/xxxx

4d. Member ID:

5d. Name of Other Insurance Carrier:

6d. Policy Number:

7d. Employer Name:

8d. **Any person who knowingly files a statement of claim containing any misrepresentation of any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties. I certify that the information supplied is true and correct.**

_____ _____

Member or Parent/Guardian Signature Date

E. Assignment of Benefits

1e. Please sign below only if you want TrueCare to pay benefits directly to the provider.

_____ _____

Member or Parent/Guardian Signature Date

Guidelines for Submitting Claims to TrueCare

- Clip all bills to the completed form and mail them to TrueCare at the address listed below. Please do not use staples to attach bills.
- Make sure all bills have a diagnosis code, procedure code, date of service and cost.
- Provide a copy of either a UB92 or HCFA1500 form (you can get this form from your provider of service.)
- Please add your Member ID number to all documents and send all claims to TrueCare in a timely manner.
- Submit claims to: TrueCare, P.O. Box 8730, Dayton, OH 45401-8730

MS-MED-M-3557951 DOM Approved: 3/3/2025