maestro health
Working together. For your benefit(s).

## Claim Form

**INSTRUCTIONS:** Please type or print the required information. If the patient receiving the service is not you, please indicate the relationship (spouse or dependent child). Sign and return a copy of this form by mail to **Maestro Health, P.O. Box 1178, Matthews, NC 28106 or fax it to 704.845.5629. You may contact Maestro Health at 1.800.279.1171 or support@maestrohealth.com with any questions.**

| *Claim Type (Circle one):* | *PPO Medical* | *Non-PPO Medical* | *Dental* | *Prescription drug* | *Vision* |
|---|---|---|---|---|---|

## *SECTION (I) - PERSONAL INFORMATION*

| **Employee Last Name** | **Employee First Name** | | **Employee Middle Initial** |
|---|---|---|---|
| **Member ID** | **Home Phone Number** | **Work Phone Number** | **E-mail address** |
| **Patient Name (write "self" if you)** | **Patient relationship to you** | **Patient Date of Birth** | **Employer Group Number and Name** *(group number is assigned by Maestro Health)* 631 - Fort Worth Firefighters |

## *SECTION (II) - ACCIDENT INFORMATION*

If this claim is a result of an accident, you must complete an Accident Information Letter. A copy of the letter can be obtained by E-mailing support@maestrohealth.com.

## *SECTION (III) - OTHER INSURANCE INFORMATION - Complete this section completely.*

| *Please read the question below and check yes or no in the box to the right* | *YES* | *NO* |
|---|---|---|
| Is the patient covered by any other group medical plan besides this Plan? | | |
| Is the patient covered by any other private medical, dental, or accident insurance plan? | | |
| Is the patient covered by any government sponsored medical plan such as Medicare or Medicaid? | | |

***If you answered yes, please furnish details about any other insurance in the box below.***

| Name of other insurance carrier: | Policy Number of other carrier: |
|---|---|
| Effective Date of other insurance: | Other carrier's phone #: |
| List all family members covered by this plan: | |

## *SECTION (IV) - EMPLOYEE CERTIFICATION AND SIGNATURE*

*I hereby certify that all information on this claim is accurate and that no information has been omitted.*

| **Employee Signature** | **Date** |
|---|---|
| | |

**For fastest service, please fax the claim in with supporting documentation.**