**Lucent Health**
P.O. Box 7020
Appleton, WI 54912-7020

**Group #:**

**Employer:**

# Health Claim Form

Phone: 920.968.4613
Fax: 920.968.4616
www.lucenthealth.com

| | | | |
|---|---|---|---|
| **Select type of health claim:** | Dental | Medical | Vision |

**Employee Information**

| | |
|---|---|
| Employee Name: | |
| Employee Address: *Street City State Zip* | |
| Work Phone Number: | Home Phone Number: |
| Employee Date of Birth: | Member ID Number: |

**Patient Information**

| |
|---|
| Patient Name: |
| Patient's Relationship to Insured: |
| Patient's Address: *Street City State Zip* |
| Patient's Date of Birth: |
| Do you or any of your covered dependents have other insurance? Yes No If yes, please indicate name and phone number of other insurance company: |

**Payment Information:**

Please make payment to: Employee Healthcare Provider

**Required Attachment:**

This form serves as a coversheet for submitting **health claims**. Your claim will need to be **accompanied by a detailed invoice** from the healthcare provider of service with the following information:

- ✓ Provider's Name, Address, Tax Identification Number, and Phone Number
- ✓ Patient's Name
- ✓ List of Services – *ICD-10 diagnosis codes and/or description and CPT or ADA procedure codes and/or description*
- ✓ Date of Service
- ✓ Charged Amount for Each Service

**Please note**: A receipt is not an acceptable form for reimbursement. Without the above information, a claim cannot be processed.

Healthcare provider of service's invoice is attached

The above statements are true and complete to the best of my knowledge and belief. I hereby authorize any hospital or physician who has treated me or my eligible dependent, or other person who has attended or examined me or my eligible dependent, or any company or government agency to furnish Lucent Health, any and all information with respect to any illness, injury, medical history, consultations, prescriptions, treatments or benefits, and copies of all applicable records. A photo copy of this form will be as valid as the original. Any person who knowingly, and with the intent to defraud or deceive any insurance company, files an application or claim containing any false, incomplete, or misleading information is guilty of a felony.

**Employee's Signature** _____ **Date** _____