





## Instructions for filing a claim

- A. **IMPORTANT.** This claim form is only to be used by subscribers of Memorial Hospital Medical Network.
- B. **COMPLETE SUBSCRIBER'S STATEMENT OF CLAIM.** Be sure to fill in any space that is applicable.
- C. Complete: "Authorization to Release Information."
- D. Complete: "Authorization of Payment" if bill **has not** already been paid by you.
- E. If claim is for prescription drugs, attach bills to form after completing "Statement of Claim" section. All bills must show: patient's name, prescription number, name of drug, date(s) of purchase, charge, and prescribing physician.
- F. If claim is for services of a non-member provider, attach bills to form after completing "Statement of Claim" section. All bills must show: patient's name, date(s) of treatment (diagnosis), procedure code, location of service, fee for each service and the tax identification number of the provider of services.
- G. If claim is for registered nurses, medical equipment or other authorized medical services, attach bill to the form after completing "Statement of Claim" section. All bills must show patient's name, nature and date(s) of services, place-of service, amount of charge, name of prescribing physicians and the tax identification number of the provider of services. The claims processing agent will request additional data only as required.
- H. **Mail the completed form to:**
  - Network Claims Administration**
  - P.O. Box 828**
  - Colorado Springs, CO 80901-0828**