Medical Claim Reimbursement Form

130 DeSiard Street, Suite 300
Monroe, LA 71201
(318) 361-0900
(318) 361-2159 Fax

Please complete a separate claim form for each patient. Allow up to 30 days from the date you submit the completed claim form for a response from Vantage. Keep a copy of all documents you submit for your records. Please mail or fax the completed claim form and a copy of all receipts and itemized health care provider bills with this form to Vantage. You must request an itemized bill from each physician or health care provider that includes: date of service, provider name, address, tax ID number and NPI number, diagnosis, revenue/procedure code(s) and the amount charged for each service provided. Please submit claim(s) within 90 days of the date of service. Claims must be submitted within 365 days of the date of service; claims not received within this time frame are not eligible for benefit payment. Submission of this form does not guarantee reimbursement.

PATIENT INFORMATION		INSURED INFORMATION (on ID Card)
Patient Name		Insured Member ID Number and Dependent Code
Patient Birth Date _____/_____/_____ Mo Day Year	Relationship to Insured Member ☐ Self ☐ Son ☐ Spouse ☐ Daughter	Insured Member Name
Patient Address		Insured Member Address
City, State, Zip		City, State, Zip
Employer's Name		Telephone Number
Does the patient have other health insurance coverage? ☐ Yes ☐ No		Was this medical expense the result of a ☐ Motor Vehicle Accident ☐ Work-related Injury If either box above is checked, are you aware of any pending legal action related to this accident? ☐ Yes ☐ No
Name of Other Health Insurance Company		
Other Health Insurance Policy Number		Please briefly describe patient's accident or sickness:
Diagnosis Code		

INSURED MEMBER AUTHORIZATION

I understand that any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false, incomplete or misleading information concerning any fact material thereto commits a fraudulent insurance act, which is a crime punishable by fine and imprisonment under Federal and State laws.

Signature of Insured Member: ____ Date: ____________________

OFFICE USE ONLY

Auth #	Referring Physician	Referred To

Date of Service	Provider of Service	Procedure Code	Charges
Notes			**Total Charges** **$** __________