Statement of Claims

MEDICA®

Medica
P.O. Box 30990
Salt Lake City, UT 84130

For medical claims, please complete this form and the Health Insurance Claim Form. If you have questions, please contact Medica Customer Service at 952-945-8000 or toll free outside the Twin Cities metro area at 1-800-952-3455. TTY users, call 711.

Throughout this form, all self-insured enrollees will be referred to as "members" rather than their formal title of "self-insured enrollees."

Note: ***For pharmacy claims, please use the Prescription Claim Form, available at medica.com/memberforms. For foreign claims, please contact Customer Service at the phone number on the back of your ID card for special instructions.***

TO BE COMPLETED BY MEMBER

Member Information

1. Member's name	2. Employer's name
3. Member ID Number (9 digits)	4. Group/Policy number (5 or 6 digits; not the Payer ID)

5. Residence street address City State ZIP

Patient Information

6. Patient's name	7. Patient's date of birth
8. Describe illness or injury	9. Give date it began

10. Check appropriate box below if claim was due to one of the following
☐ Auto accident ☐ Dental injury ☐ Emergency ☐ Mental health or substance abuse

11. If injury, was it job related? ☐ Yes ☐ No
If Yes, please explain:

12. Do you or does any member of your immediate family have any other group insurance which may cover all or part of this claim? ☐ Yes ☐ No
If Yes, give insurance company name, address and group/policy number:

A person who submits an application or files a claim with intent to defraud or helps commit fraud against an insurer is guilty of a crime.

Authorization: On behalf of myself and any patient named on this claim form ("Us"), I authorize any health care professional or entity, employer, union, insurance company, health maintenance organization, other health plan company or prepayment organization to give Medica Health Plans, Medica Insurance Company, Medica Health Plans of Wisconsin, or Medica Self-Insured and my employer, or any of their designees, any and all records or information pertaining to medical history or services rendered to Us for evaluation of this claim, and for any analytical or research purposes. This authorization will automatically expire one year following the date of signature without my express revocation.

Member's signature	Date

Please ensure that this entire claim form has been properly completed and signed prior to submitting to Medica. Payment will be made to you, unless you sign #13 on the Health Insurance Claim Form, or specifically direct otherwise.

Mail these forms and/or itemized bills to:
Medica
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Salt Lake City, UT 84130