



Health Design Plus does not insure benefits under the Plan. Your employer is solely responsible for determination of, entitlement to, and payment of, any amounts due under the plan.

# Health Design Plus

## Medical Benefits Request Form

**Remember:** To avoid delays, be sure employee's social security number is provided in item #9.

### Information we need to process this claim (type or print)

1. Patient's Name (First, M.I., Last)		2. Patient's Date of Birth Month   Day   Year		3. Employee's Name (First, M.I., Last)	
4. Patient's Address (if different from employee) Street _____		5. Patient's Sex <input type="checkbox"/> Male <input type="checkbox"/> Female		6. Employee Address and Phone No. (check if new address) <input type="checkbox"/> Street _____	
City _____ State _____ Zip Code _____ Telephone No. _____		7. Patient's Relationship to Employee <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other		City _____ State _____ Zip Code _____ Telephone No. _____	
8(a). Is Patient presently employed other than at this plan? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Enter Name and Address of Employer		9. Employee's Social Security Number		10. Employers Name / Group Number	
8(b). Is Patient covered by another Group Health Plan? (Including Government Sponsored Plans and Medicare) <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Enter:  (Name of Policy Holder)		11. Was condition related to: A. Patient's Employment? <input type="checkbox"/> Yes <input type="checkbox"/> No B. An Accident? <input type="checkbox"/> Yes <input type="checkbox"/> No		12. If an accident Date _____ and Time _____ <input type="checkbox"/> A.M. <input type="checkbox"/> P.M. Description (How & When)  Is there a third party payor? <input type="checkbox"/> Yes <input type="checkbox"/> No	
(Plan Name) _____ (Policy or Medicare No.) _____ (Name and Address of Plan Administrator or Carrier)					
13. I authorize the release of any information necessary to process this request. I also authorize the release of this information to any third party acting on behalf of my employer, its subsidiaries, or its agents to perform health care claims data evaluation and analysis, and to notify the facility medical department of any hospital stays.  Signed (Patient or Parent, if Minor) _____ Date _____			14. I authorize payment of medical benefits to undersigned physician or supplier for service described below.  Signed (Employee or Spouse) _____		

### Information to be completed by your physician or supplier (type or print)

15. Date of Illness (first symptoms) or injury (accident) or pregnancy (LMP)		Date first consulted you for this condition		17. Has patient ever had same or similar symptoms? <input type="checkbox"/> Yes <input type="checkbox"/> No		18. Is this claim for ambulatory surgery? <input type="checkbox"/> Yes <input type="checkbox"/> No	
19. Name of Rendering Physician				20. For services related to hospitalization Give hospitalization dates: Admitted _____ Discharged _____			
21. Name and Address of Facility where services rendered (If other than home or office)				22. Was Laboratory work performed outside your office/ <input type="checkbox"/> Yes <input type="checkbox"/> No Charges:			
23. Diagnosis or nature of illness or injury (Show ICD-9-CM Code and relate diagnosis to procedure in column E by reference to number 1 or 2) 1. _____ 2. _____							
24. A) Date of Service	B) Place of Service**	C) Procedure Code*** (Identify CPT)	D) Fully describe procedures, medical services or supplies furnished for each date given.	E) Units or Diagnosis Code	F) Charges	G) Remarks	
25. Signature of Physician or Supplier Signature _____ Date _____		26. Enter the taxpayer identifying number to be used for 1099 reporting purposes. You are required under authority of law to furnish your taxpayer identifying number		27. Total Charge	28. Amount Paid	29. Balance Due	
30. Physician's or Supplier's Name, Address, Zip Code and Telephone Number				31. Your Patient's Account Number			

\*\*Place of Service Codes  
 1 - (IN) - Inpatient Hospital      4 - (H) - Patient's Home      7 - (NH) - Nursing Home      O - (OL) - Other Locations  
 2 - (HO) - Outpatient Hospital    5 - Day Care Facility (PSY)    8 - (SNF) - Skilled Nursing Facility    A - (IL) - Independent Laboratory  
 3 - (O) - Doctor's Office          6 - Night Care Facility (PSY)    9 - Ambulance                                B - Other Medical Surgical Facility

\*\*\*Please use current procedure terminology codes for surgery.

## HOW TO REQUEST MEDICAL BENEFITS

### Employee

1. Each time you request benefits, complete the first section (items 1 through 13) on the reverse of this form.
  - Use a separate **Medical Benefits Request Form** for each member of the family.
  - **All benefits will be paid to the member at the out of network level**, leave item 14 blank.
  - If you wish to **receive the benefit payment yourself**, leave item 14 blank.
2. Ask your doctor, hospital or supplier to complete the physician or supplier information (items 15 through 32) or attach itemized bills. You will need a diagnosis, doctor's charges from your doctor, CPT code and your provider's billing address and zip code.

Itemized bills should include:	Doctor's Name	Patient's Name
	Date of Service	Condition Being Tested
	Charge for Service	

3. **If you or your dependent(s) are eligible for Medicare, you must include the statement(s) of payment or rejection from Medicare, part A and Part B.**
4. If you or any of your dependents have primary coverage with another Group Plan, you must include the primary carrier's statement of payment or rejection of the claim, and the corresponding charges with the claim submitted to the address listed on your Identification Card.
5. Double check the claim form to verify that all questions have been answered. A completed claim form is very important to avoid delays in claim processing.

### Doctor, Hospital or Supplier

1. Complete items 16 through 33 on the **Medical Benefits Request Form** using current CPT procedure and ICD-9-CM diagnosis codes.
2. Send this request to:

**HDP  
P.O. Box 2584  
Hudson, OH 44236**