Medical Claim Form - Covenant

YOUR CLAIM CANNOT BE PROCESSED UNLESS THIS FORM IS COMPLETE.

Member ID Number: _____

Insured's Name: _____ Group Number: _____
Last First M.I.

Insured's Address: _____
Street City State Zip

Home Phone: _____ Work Phone: _____

Patient Name: _____ Patient Birth Date: _____
Last First M.I.

Relationship to Insured:

☐ Insured ☐ Dependent

☐ Spouse ☐ Other: _____

Date of Service: _____ Provider: _____

Were you on board a cruise ship? ☐ Yes ☐ No

Please check the physical location of the cruise ship at time of treatment:

☐ Outside US territorial waters, OR ☐ Within US territorial waters

If within US territorial waters please provide closest port or city _____ OR the number of hours to the closest US port/city _____ hours

☐ Pay to Member ☐ Pay to Provider ***(must submit unassigned claim form from provider)***

For member reimbursement attach:

- Detailed claim from provider that has the following information: member name, member DOB, member ID, provider name, provider address, provider phone number, provider TIN, provider NPI, diagnosis code(s), date of service, procedure code(s), billed amount charged for each service performed

Mail to:

Baylor Scott & White Health Plan
Attn: Pay Me
1206 West Campus Drive
Temple, TX 76502