# MDWISE MARKETPLACE MEMBER CLAIM FORM

**A PATIENT INFORMATION**

| PATIENT'S ID NUMBER / SSN | PATIENT'S BIRTHDATE MM DD YY | MALE | FEMALE |
|---|---|---|---|
| | | | |

| PATIENT'S NAME<br>Last Name, First Name, Middle Initial | RELATIONSHIP TO SUBSCRIBER SELF | SPOUSE | CHILD | OTHER |
|---|---|---|---|---|
| | | | | |

PATIENT'S ADDRESS (No, Street)

| CITY | STATE |
|---|---|
| | |
| ZIP CODE | HOME PHONE NUMBER (Include Area code) |
| | |
| COUNTRY | WORK PHONE NUMBER (Include Area code) |
| | |

PATIENT NEW ADDRESS ☐ YES ☐ NO

**B SUBSCRIBER INFORMATION**

| SUBSCRIBER'S ID NUMBER/SSN | SUBSCRIBER'S BIRTHDATE MM DD YY |
|---|---|
| | |

SUBSCRIBER'S NAME
Last Name, First Name, Middle Initial

SUBSCRIBER'S ADDRESS (No, Street)

| CITY | STATE |
|---|---|
| | |
| ZIP CODE | HOME PHONE NUMBER (Include Area code) |
| | |
| COUNTRY | WORK PHONE NUMBER (Include Area code) |
| | |

INSURED NEW ADDRESS ☐ YES ☐ NO

**C ACCIDENT INFORMATION**

Is the condition or injury job related?
☐ YES ☐ NO

If yes, what date did the Injury occur?
____/____/____

Is this service billable to Worker's Compensation?
☐ YES ☐ NO

**D OTHER INSURANCE INFORMATION**

Does the Patient Have Other Health Insurance Coverage?
☐ YES ☐ NO

Note: If another Insurance or Medicare is primary, attach a copy of the Explanation of benefits (EOB)

**E ASSIGNMENT OF BENEFITS**

Please sign below only if you want MDWise Marketplace Health plan to pay benefits directly to the provider of medical services.

| Subscriber Signature: | Date: |
|---|---|
| | |

**F SERVICES AND BILLED CHARGES - Please Include itemized receipt from Provider as noted on Form**

Diagnosis Code

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| A | ______ | B | ______ | C | ______ | D | ______ |
| E | ______ | F | ______ | G | ______ | H | ______ |
| I | ______ | J | ______ | K | ______ | L | ______ |

**CLAIM DETAILS**

| Date of Service (MM/DD/YYYY) | Procedure Code | Charges ($) |
|---|---|---|
| | | |
| | | |
| | | |

| Provider Federal Tax ID | Total charges $<br>Amount Paid $ |
|---|---|

Provider of Service (Name of Doctor, clinic, laboratory, hospital, etc)

Provider Name:

Provider Street Address:

Provider City, State and Zip Code:

I Certify that, to the best of my knowledge the information on this Member Claim Form is true and correct. I authorize the release of any medical information necessary to process this claim.

| Subscriber Signature: | Printed Name: | Date: |
|---|---|---|
| | | |

**Member Billing Guidelines:**

Clip, do not staple, all bills to the completed form and mail to MDWise Marketplace at address noted below:

MDwise Marketplace
PO Box 331428
Corpus Christi, TX 78463-1428

Please indicate a diagnosis code, procedure code, date of service and charges in field F.
Submit all claims to MDWise Marketplace in a timely manner. (Member claims filing limit 90 days from date of service)
Please include Subscriber # / Patient # on all documents.