



**MDWISE MARKETPLACE MEMBER CLAIM FORM**

A PATIENT INFORMATION				B SUBSCRIBER INFORMATION					
PATIENT'S ID NUMBER / SSN		PATIENT'S BIRTHDATE		SUBSCRIBER'S ID NUMBER/SSN		SUBSCRIBER'S BIRTHDATE			
		MM	DD	YY			MM	DD	YY
PATIENT'S NAME		RELATIONSHIP TO SUBSCRIBER		SUBSCRIBER'S NAME					
Last Name, First Name, Middle Initial		SELF	SPOUSE	CHILD	OTHER	Last Name, First Name, Middle Initial			
PATIENT'S ADDRESS (No, Street)					SUBSCRIBER'S ADDRESS (No, Street)				
CITY		STATE		CITY		STATE			
ZIP CODE		HOME PHONE NUMBER (Include Area code)		ZIP CODE		HOME PHONE NUMBER (Include Area code)			
COUNTRY		WORK PHONE NUMBER (Include Area code)		COUNTRY		WORK PHONE NUMBER (Include Area code)			
PATIENT NEW ADDRESS <input type="checkbox"/> YES <input type="checkbox"/> NO				INSURED NEW ADDRESS <input type="checkbox"/> YES <input type="checkbox"/> NO					
C ACCIDENT INFORMATION				D OTHER INSURANCE INFORMATION					
Is the condition or injury job related? <input type="checkbox"/> YES <input type="checkbox"/> NO				Does the Patient Have Other Health Insurance Coverage? <input type="checkbox"/> YES <input type="checkbox"/> NO					
If yes, what date did the Injury occur? ____ / ____ / ____				Note: If another Insurance or Medicare is primary, attach a copy of the Explanation of benefits (EOB)					
Is this service billable to Worker's Compensation? <input type="checkbox"/> YES <input type="checkbox"/> NO									
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:			
<b>F SERVICES AND BILLED CHARGES - Please Include itemized receipt from Provider as noted on Form</b>									
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 \$					
				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.