

**** Before completing, please read the instructions below and on the back to ensure fast, accurate processing****



CLAIM FORM

1.

Claimant's Statement.
Please, only one patient per form.

Your Certificate Number: 040 _____
(As shown on your ID Card and Schedule of Benefits)

Member's Name _____
(Last, First, MI)

Street Address _____ Telephone # (_____) _____

City _____ State _____ ZIP _____

Patient's Name _____ Date of Birth _____

Diagnosis or Description of Condition _____

2.

Assignment of Benefits. READ CAREFULLY. Complete this section only when you wish payment to be made directly to the provider(s) of service.
(If more than one provider, list each on a separate piece of paper.)

Provider's Name (hospital, doctor, etc.) _____

Street Address _____

City _____ State _____ ZIP _____

Provider's Telephone Number (_____) _____

Your Signature X _____ Date X _____

3.

Need Help?
Have Questions?
Call 1-800-247-2192.

Any Person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information, or conceals for the purpose of misleading information concerning any fact material, thereto, commits a fraudulent act, which is a crime.

INSTRUCTIONS

- 1) Complete all requested information on front, sign and date reverse of form.
- 2) Complete Section 2 ONLY if you want us to pay your insurance benefits to the Provider (for example, doctor, clinic, hospital, etc.).
- 3) Enclose a copy of your TRICARE Explanation of Benefits Form. Jot your certificate number on the copy.
- 4) If your claim is for benefits under the MOAA Hospital Income Plan, send a copy of the hospital bill showing admission and discharge dates.
- 5) For TRICARE Supplements, if services were provided in a Civilian hospital, please attach a copy of the TRICARE Explanation of BENEFITS Form; if services were provided in a Government Hospital, a copy of your Subsistence fee receipt is needed; if you have TRICARE Prime coverage, please submit a copy of your bill showing amount of charges and also the copayment amount.
- 6) Mail Claim to: MOAA Insurance Plans, ATTN: Claims, P.O. Box 9126 Des Moines, IA 50306

In the majority of cases, the information contained on this form is all that is required to process a claim. In some cases, additional information may be needed, requiring the claimant to complete and submit a more detailed form.

ATTENTION

Please read the statement that applies to your state of residence and date and sign on space provided at the bottom of this form:

California Residents Only: For your protection California Law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Colorado Residents Only: It is unlawful to knowingly provide false, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Florida Residents Only: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Pennsylvania Residents Only: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading information concerning any fact material thereto commits a fraudulent insurance act, which is a crime, and subjects such person to criminal and civil penalties.

Alaska, Arkansas, Delaware, Indiana, Kentucky, Minnesota, New Hampshire, New Jersey, New Mexico, New York, Ohio, Oklahoma Residents: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading information concerning any fact material thereto commits a fraudulent insurance act, which is a crime, and shall also be subject to a substantial civil penalty where and to the extent allowed by state law.

Signature _____ Date _____