MARPAI

Claim Form

INSTRUCTIONS: Please type or print the required information. If the patient receiving the service is not you, please indicate the relationship (spouse or dependent child). **Sign and return a copy of this form along with your itemized receipt or bill by uploading to your member portal, email: claims@marpaihealth.com, or faxing to 704.845.5629.**

Claim Type (Circle one):	*PPO Medical*	*Non-PPO Medical*	*Dental*	*Vision*	

SECTION (I) - PERSONAL INFORMATION

Employee Last Name	**Employee First Name**		**Employee Middle Initial**
Member ID	**Home Phone Number**	**Work Phone Number**	**E-mail address**
Patient Name (write "self" if you)	**Patient relationship to you**	**Patient Date of Birth**	**Employer Group Number and Name** *(group number is assigned by Maestro Health)*

SECTION (II) - ACCIDENT INFORMATION

If this claim is a result of an accident, you must complete an Accident Information Letter.

SECTION (III) - OTHER INSURANCE INFORMATION - Complete this section completely.

Please read the question below and check yes or no in the box to the right	*YES*	*NO*
Is the patient covered by any other group medical plan besides this Plan?		
Is the patient covered by any other private medical, dental, or accident insurance plan?		
Is the patient covered by any government sponsored medical plan such as Medicare or Medicaid?		

If you answered yes, please furnish details about any other insurance in the box below.

Name of other insurance carrier:	Policy Number of other carrier:
Effective Date of other insurance:	Other carrier's phone #:
List all family members covered by this plan:	

SECTION (IV) - EMPLOYEE CERTIFICATION AND SIGNATURE

I hereby certify that all information on this claim is accurate and that no information has been omitted.

Employee Signature	**Date**

For fastest service, please fax or email **the claim in with supporting documentation.**

You may also mail to:

MarpaiHealth
PO Box 211291
Eagan, MN 55121