INSTRUCTIONS FOR FILING A MEDICAL CLAIM

Please read all instructions carefully before completing the Medical Claim Form.

Note: If you are a Medicare member, please see page two for additional instructions related to filing a Medical Claim.

If you incurred a covered medical expense or paid out-of-pocket and need to be reimbursed, you will send in this form. For medication and international claims, use the designated Pharmacy and/or International claim forms.

1. This form is only needed to submit claims for services and supplies that are not submitted by your provider (i.e., out-of-network doctors and hospitals). You must file your claim within one year from the date of service. You can submit your claim any time during the year.
2. Use a separate claim form for each family member and each physician or supplier.
3. All sections of the form must be filled out completely or your claim may be returned to you.
4. **If your claim is a result of an accident,** please provide a copy of the auto carrier's Explanation of Benefits or Letter of Exhaustion (if available).
5. **If you have other insurance, please provide a copy of your ID card(s)** and send a copy of Explanation of Benefit (EOB) statements from the other insurance company for the claim you are submitting (i.e., Medicare, Health, Auto or Workman's Comp).
6. **If your claim is for Durable Medical Equipment** (i.e., wheelchair, respirator, oxygen, etc.), you must submit the prescription along with a letter of medical necessity from the treating physician.
7. **Your original itemized Bills and Receipts must include:**
   - □ Physician or supplier name
   - □ Physician or supplier address
   - □ Physician or supplier Tax ID and NPI (National Provider ID)
   - □ Member name
   - □ Patient's full name (if different from member)
   - □ Type of service and procedure code
   - □ Date of service or purchase
   - □ Diagnosis and diagnosis code
   - □ Condition being treated
   - □ Charge for each service rendered (may be found on itemized bill or receipt)

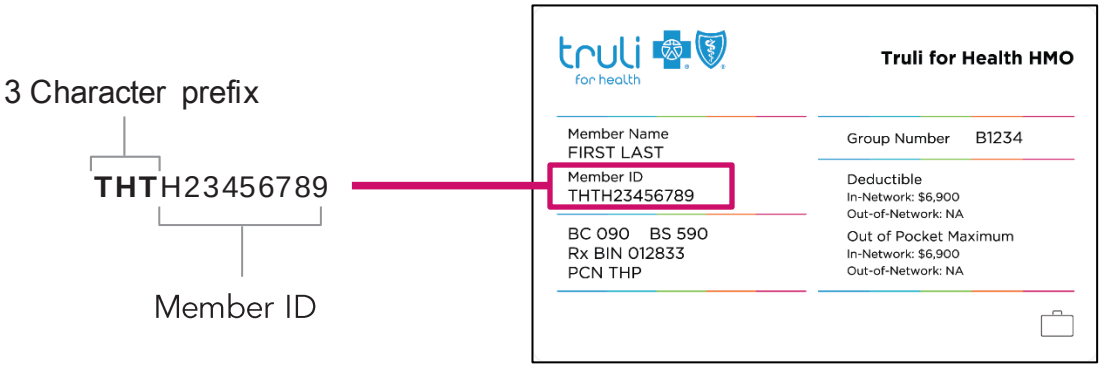
   Important: You must submit original bills or receipts from your provider. Please keep a copy as the originals cannot be returned.
8. Please be aware that if the provider or supplier is contracted with Truli for Health, payment will be made to the provider. If this is a contracted provider and you have paid in full for services, you will need to seek reimbursement directly from the provider.
9. If this claim is for a non-contracted provider, payment may be made to you or to the provider. You may sign the AUTHORIZATION OF PAYMENT section to have payment sent directly to the provider.
10. **Please be sure to review your claim form and documents carefully to ensure we can process your claim accurately and quickly.**

INSTRUCTIONS FOR FILING A MEDICAL CLAIM

Helpful tips for locating your Member ID number

The Member ID is a combination of alpha and numeric characters. A correct Member ID number includes the prefix (first three characters) and nine subsequent characters beginning with "H" with the exception of Blue Medicare "Premier" Members and "Value" Rx ID Cards which have no alphanumeric prefix.

An example Member ID number is THTH23456789 and is located on the front of your Member ID card.



Example Member ID card for illustrative purposes.

MAILING ADDRESS

Please mail your completed claim form with original bills or receipts and copies of other Explanation of Benefits, if applicable to:

Truli for Health
P.O. Box 45014
Jacksonville, FL 32232

Medicare Members: *You do not have to use this form, but it will help us process the information faster.*

We will pay your provider unless you have already paid them. We will reimburse you if you submit proof of payment, such as:

- A credit or debit card receipt showing you paid the provider
- A credit or debit card (bank) statement showing you paid the provider
- A copy of a canceled check (front and back) showing you paid the provider
- A copy of a credit or debit card receipt/statement and an itemized description of services received on a cruise ship

Non-Medicare Members: You may ask us to pay your provider. Or, if you want to be reimbursed for a service, you must send us proof you were charged for a covered service. Examples of this include:

- A superbill: An itemized bill from your doctor that includes the information in step number seven (see instructions page 1)
- A letter or statement from your provider that includes the information in step number seven (see instructions page 1)

MEDICAL CLAIM FORM (Subscriber/Policyholder to complete)

Enter your Member number & group number from your **Truli for Health Member ID card**.

MEMBER'S INFORMATION (The policy holder name shown on the front of your ID card.)			
Member's Legal Name (Last, First, Middle Initial)			Date of Birth (MM/DD/YYYY)
Member's Street Address, check box if new address □	City	State	Zip Code
Member Number (From the front of your ID card) Prefix — Member ID starting "H"	Group Number (if applicable)	Employer Name (if applicable)	

PATIENT INFORMATION		
Patient's Legal Name (Last, First, Middle Initial)		Date of Birth (MM/DD/YYYY)
Patient's Relationship to Member □ Self □ Spouse □ Child □ Other		
Patient's Gender □ Male □ Female		

OTHER HEALTH INSURANCE (Complete only if you have other health insurance and/or Medicare)		
Name of Insuring Company		Effective Date (MM/DD/YYYY)
Street Address	City	State / Zip Code
Name of Policyholder (Last, First, Middle)		Policy Number

MEDICARE	
Medicare Part A (Hospital Insurance) □ Yes □ No	Effective Date (MM/DD/YYYY)
Medicare Part B (Medical Insurance) □ Yes □ No	Effective Date (MM/DD/YYYY)
Medicare HMO/Prepaid Plan □ Yes □ No	Effective Date (MM/DD/YYYY)

PATIENT MEDICAL INFORMATION (May be found on Itemized Bill or Receipt)

	Service Date (MM/DD/YYYY)	Procedure Code	Diagnosis Code	Charge for Service
1				
2				
3				

MEDICAL CLAIM FORM (Subscriber/Policyholder to complete)

truli for health

PHYSICIAN OR SUPPLIER INFORMATION			
Name			
Street Address	City	State	Zip Code
Provider NPI	Tax ID		

ACCIDENT / INJURY /ILLNESS DETAILS

Attach a description of how the accident or work-related injury or illness occurred.
For car accidents, include a copy of your auto insurance Letter of Exhaustion. Please be sure that duplicate bills are not submitted.

Was this medical expense the result of an accident? □ Yes □ No

Have you filed Worker's Compensation? □ Yes □ No

Was the treatment the result of a work-related injury? □ Yes □ No

When did this accident/injury/illness occur (MM/DD/YYYY)?

AUTHORIZATION AND SIGNATURE REQUIRED

I certify the above is complete and correct and that I am claiming benefits only for charges incurred by the patient named above. Authorization is hereby given to any hospital, physician, or other provider which participated in any way in my care and treatment to release to Truli for Health any medical information which they in their judgment deem necessary to the adjudication of this claim.

IMPORTANT: Any person who knowingly and with intent to injure, defraud, or deceive any insurance company files a statement of claim containing any false, incomplete or misleading information is guilty of a felony of the third degree. Florida Statutes, Section 817.234.

Date (MM/DD/YYYY)

Signature of Policy Holder X

AUTHORIZATION OF PAYMENT TO NON-CONTRACTED PROVIDERS

I authorize Truli for Health to make payment of benefits directly to the provider(s) indicated on the enclosed bills/receipts in those situations where such provider(s) is/are non-contracted provider(s) and Florida law requires direct payment when authorized.

NOTE: Should any such provider also submit a claim for the same services and informs us that the benefits have been assigned, we may honor that assignment should the authorization on this form be signed or not signed.

Date (MM/DD/YYYY)

Signature of Policy Holder X

MEDICAL CLAIM FORM

Health coverage is offered by Truli for Health, an affiliate of Florida Blue. These companies are Independent Licensees of the Blue Cross and Blue Shield Association.

Truli for Health is an HMO plan with a Medicare contract. Enrollment in Truli for Health HMO depends on contract renewal

We comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability or gender.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 855-308-7854.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 855-308-7854.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 855-308-7854.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 855-308-7854.