Medical Claim Form

MEDICAL MUTUAL®

Use your provider's itemized bill(s) to complete the below form. **Save this PDF to your computer prior to filling out the form**. Please submit a separate claim form for each provider visited. Your cooperation in fully completing this form and providing necessary documentation will help ensure quick and accurate processing.

Section 1: Subscriber Information

Last Name	First Name	M.I.

ID Number (Found on Medical Mutual of Ohio ID card)	Date of Birth __ /__ /____	Sex ☐ Male ☐ Female

Section 2: Patient Information *(If different from subscriber)*

Patient Last Name	Patient First Name	M.I.	Sex ☐ Male ☐ Female

Date of Birth __ /__ /____	Relationship to Subscriber

Section 3: Coordination of Benefits - Other Insurance

Does the patient have other health insurance coverage? ☐ Yes ☐ No	

Subscriber Name	Name of other insurance company	Group No.	Policy No.

Section 4: Medical Information

Health care services: Use this section to report any covered health service that has not already been reported to this Medical Mutual plan by the provider of service (the physician, clinical, ambulance company, private duty nurse, etc.).

Where was the service rendered? ☐ Physician office ☐ Hospital Outpatient ☐ Hospital Inpatient ☐ Ambulance ☐ Medical equipment supplier ☐ Pharmacy ☐ Laboratory ☐ Other

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

When did this injury or accident occur? (MM/DD/YYYY) __ /__ /____

Was this service or injury job related? ..... ☐ Yes ☐ No

Date of Service	Diagnosis Code	Procedure Code (CPT)	Provider Tax ID	Amount
__ /__ /____				$
__ /__ /____				$
__ /__ /____				$
			Total	$ 0

Each claim form should be submitted with an itemized bill. Each itemized bill must include:

- Name and address of provider (doctor, hospital, laboratory, ambulance service, etc.)
- Name of patient
- Service provided
- Date of service
- Amount charged for each service
- Diagnosis code
- Procedure code
- Tax ID

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

Signature X	Printed name	Date (MM/DD/YYYY)

Select 'Print' to mail your completed form and itemized bill to: Medical Mutual, P.O. Box 6018 Cleveland OH 44101-1018.
Select 'Submit' to send your completed form in an email message. Please attach the itemized bill in your message.

PRINT

SUBMIT