First Choice Health®

Claim Submission Address:
FCHA, Attn: Claims,
PO Box 12659,
Seattle, WA 98111-4659

1 - MEMBER/ PATIENT

Member Name: *(First, Middle, Last)*	**Member Number:**	**Group Number:**		
Address: *Is this a New Address?* ☐ *Y* ☐ *N*	City	State	Zip Code	**Birth Date:**
Patient Name: (First, Middle, Last)	**Patient's relationship to member:**			**Sex:**
	☐ Self ☐ Spouse ☐ Child ☐ Handicapped Dependent ☐ Other			☐ M ☐ F

Does the patient have other health insurance coverage? ☐ *Y* ☐ *N* **If Yes, please complete section 2.**

2 - OTHER INSURANCE

Policyholder's Name: *(First, Middle, Last)*	**Birth Date:**	**Policyholder's Member Number**	**Effective Date:**
Other Insurance carrier's information:			
Insurance Name:	Address:		
City	State	Zip Code	Phone Number:
			( )
Policyholder's employment status:			**Patient's relationship to member:**
☐ Active ☐ Disabled ☐ Retired ☐ Effective Date: ____/____/____			☐ Self ☐ Spouse ☐ Child ☐ Other
Type(s) of Coverage: (Check all that apply)			
☐ Hospitalization ☐ Medical-surgical ☐ Dental ☐ Vision ☐ Drug ☐ Major Medical ☐ Other(Specify):_____			
Coverage Covers: (Check all that apply)			
☐ Policyholder only ☐ Policyholder and spouse ☐ Policyholder and child(ren) ☐ Family			
Is the patient entitled to benefits under Medicare Part A or B?	☐ Yes ☐ No	If YES, complete the rest of section 2.	
Medicare effective date: ____/____/____	**Medicare ID#:**		
Member's employment status	☐ Active ☐ Retired ☐ Disabled		

3 - PATIENT CONDITION

(A)	**Please provide description of services, as well as diagnosis.** *(Include valid ICD diagnosis and CPT codes)*	**Name of doctor treating injury/illness** *(Tax ID Number must be provided)*		**Date of Symptoms**
				____/____/____
				____/____/____
(B)	**If this claim is the result of an injury, do you intend to file a claim against another individual, business, organization or insurer for damages arising from the injury:** ☐ Yes ☐ No			
(C)	**If this claim is the result of an injury, have you retained an attorney to represent you?:** ☐ Yes ☐ No If YES, complete the rest of question 3C.			
	Attorney Name:	Address:		
	City	State	Zip Code	Phone Number:
				( )
(D)	**Were the services related to a hospitalization?**	☐ Yes ☐ No If YES, complete the rest of the question 3D.		
	Admission Date: ____/____/____	Discharge Date: ____/____/____		
(E)	**Were the expenses due to an accident?**	☐ Yes ☐ No If YES, complete the rest of the question 3E.		
	Accident Date: ____/____/____ ☐ Work ☐ Auto ☐ School ☐ Other (Specify) _____			

I certify that the information provided on this claim form is correct and complete, and that I am claiming benefits actually incurred by the named patient. I authorized any hospital, physician, or other provider who participated in the care and treatment of the patient to release all medical or other information requested for the processing of the claim to First Choice Health Administrators. I hereby agree to reimburse First Choice Health Administrators in full if this claim is paid incorrectly. 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 material fact thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Member Signature	Date	(Area Code) Home Phone	(Area Code) Home Phone