FORM MCM-2

CLAIM FOR COMPREHENSIVE MEDICAL BENEFITS

Please print or type information

Mail all claims and inquiries to the Fund Office of the

MAN-U SERVICE CONTRACT TRUST FUND
7130 Columbia Gateway Drive, Suite A, Columbia, Maryland 21046
Phone: (410) 872-9500; Toll Free (800) 638-8824

This Claim Form may be used to claim benefits for: IN AND OUTPATIENT MEDICAL SERVICES, INCLUDING PHYSICIAN VISITS, PRESCRIPTION DRUG REIMBURSEMENTS (where PDI Card was not used).

MEMBER INFORMATION

Name (First name, middle initial, last name)	Birth Date	Social Security Number	Married ( ) Single ( )

Address (Street, city, state, zip code)	Telephone Number Home: Work:	Name of Employer & Local No.

PATIENT INFORMATION

Name (First name, middle initial, last name)	Birth Date	Relationship to Member: Self / Spouse / Child / Other	☐ Male ☐ Female

Date of Injury	Place of Injury	Was condition related to an accident ☐ Yes ☐ No Was condition job related? ☐ Yes ☐ No

Is Patient covered by another medical insurance? ☐ Yes ☐ No If yes, give name, address and phone number of carrier:

Patient's or Authorized Person's Signature
I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM.

Signed _____ Date _____

I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO UNDERSIGNED PHYSICIAN OR SUPPLIER FOR SERVICE DESCRIBED BELOW

Signed (Insured or Authorized Person) _____

SECTION BELOW TO BE COMPLETED BY HOSPITAL/PHYSICIAN OR ATTACH ITEMIZED BILL REFLECTING INFORMATION REQUIRED

NOTES: (1) For inpatient treatment, Hospital's itemized bill MUST BE attached.

(2) For treatment of alcoholism and/or drug abuse, whether in or outpatient, a treatment plan and an itemized bill MUST be attached.

(3) For outpatient services or surgical procedure, provider may complete the Section below or attach an itemized statement.

WAS PATIENT'S CONDITION DUE TO:

An Auto Accident? No ☐ Yes ☐ A Work Related Accident or Condition? No ☐ Yes ☐

A Medical Emergency? No ☐ Yes ☐ Any Other Accidental Injury? No ☐ Yes ☐

IF AN ACCIDENT, GIVE THE DATE OF THE ACCIDENT ___/___/___ (Mo. Day Yr.)

WAS ANOTHER PARTY AT FAULT? No ☐ Yes ☐ If yes, attach a statement with details (see accidental injury on the reverse side)

WAS PATIENT HOSPITALIZED? No ☐ Yes ☐ If yes, complete the following: Name of Hospital _____

Admission Date ___/___/___ (Mo. Day Yr.) Discharge Date ___/___/___ (Mo. Day Yr.) Name of Admitting Physician _____

A. Diagnosis or nature of illness or injury. Relate diagnosis to procedure in column D by reference numbers 1, 2, 3, etc. or Dx code →

1.
2.
3.
4.

If bill includes Anesthesiologist charges, show time involved:
Hours Minutes

A. Date of Service From	To	B* Place of Service	C. Fully describe procedures, medical services or supplies furnished for each date given: Procedure Code (Identify)	(Explain unusual services or circumstances)	D. Diagnosis Code	E. Charges

HOSPITAL OR PHYSICIAN	FED. TAX I.D. NO.

ADDRESS	TAKEN FROM RECORDS ON: 19

SIGNED BY

TOTAL CHARGES . . . . . $_____

PAYMENT CREDITS—PATIENT $_____

PAYMENT CREDITS—OTHER CARRIER(S). . . . . $_____

BALANCE DUE . . . . . $_____

*PLACE OF SERVICE CODES ON THE BACK

INSTRUCTIONS

THIS FORM IS TO BE USED TO SUBMIT A CLAIM FOR IN AND OUTPATIENT MEDICAL SERVICES UNDER YOUR HEALTH PLAN. TO AVOID HAVING YOUR CLAIM RETURNED:

- Prepare a SEPARATE CLAIM FOR for each family member.
- Complete ALL OF THE INFORMATION REQUESTED.
- If claim is for reimbursement of prescription drugs, complete only member and patient information and attach drug receipt(s) as described below.

EACH PROVIDER'S ORIGINAL ITEMIZED BILL MUST BE ATTACHED AND CONTAIN:

- The letterhead indicating the person or organization providing the service
- The name of the patient receiving the service
- A description of each service
- The date for each individual service (a range of dates cannot be accepted)
- The charge for each individual service
- The provider's Federal Tax I.D. Number

ON EACH BILL, PLEASE CROSS OUT ANY CHARGES THAT WERE INCLUDED ON A PREVIOUS CLAIM. PERSONAL ITEMIZATIONS, CASH REGISTER RECEIPTS AND CANCELLED CHECKS ARE NOT ACCEPTABLE. ITEMIZED BILLS CANNOT BE RETURNED.

IN ADDITION TO THE ABOVE REQUIREMENTS, THE FOLLOWING INFORMATION WILL BE NEEDED:

ACCIDENTAL INJURY - Statements must contain details as to when, where and the manner in which the injury occurred as well as the name and address of the party at fault.

PRESCRIPTION DRUGS - Bills must include the prescription number, the name of the drug and the name of the physician prescribing the medication.

ALCOHOLISM AND DRUG ABUSE - A Treatment Plan prepared by the physician must be submitted with claim.

PROSTHETIC APPLIANCES and the RENTAL OR PURCHASE OF DURABLE MEDICAL EQUIPMENT - A statement from the attending physician must accompany the claim. The statement should explain the medical necessity of the equipment and the physician's authorization for it.

FOR PATIENTS COVERED BY ANOTHER INSURANCE CARRIER OR MEDICARE - If the patient is claiming benefits for any charges that are eligible for benefits under any other health insurance policy or Medicare Part A and/or Part B, the Explanation of Benefits form furnished by the other carrier pertaining to these charges must be included with the itemized bills. A clear photocopy of the other carrier's Explanation of Benefits form is acceptable in place of the original document.

***PLACE OF SERVICE CODES:**

1 - (IH) - Inpatient Hospital
2 - (OH) - Outpatient Hospital
3 - (O) - Doctor's Office
4 - (H) - Patient's Home
5 - (NH) - Nursing Home
6 - (SNF) - Skilled Nursing Facility
7 - Ambulance
8 - (OL) - Other Locations
9 - (IL) - Independent Laboratory
10 - (ASC) - Ambulatory Surgical Center
11 - (RTC) - Residential Treatment Center
12 - (STF) - Specialized Treatment Facility
13 - (COR) - Comprehensive Outpatient
14 - - Rehabilitation Facility
15 - (KDC) - Independent Kidney Disease Treatment Center

BEFORE SUBMITTING YOUR CLAIM, PLEASE BE SURE THAT:

1. The claim form is fully completed and signed.
2. The itemized bills are attached.
3. You have kept copies of each document and bill for your personal records.

FOR FUND OFFICE USE ONLY

Contractor: | Period Elig.:

Contract: | Class: Rate:

Cause: _____

Processed By: _____ Date: _____

Entered By: _____ Date: _____

Paid To: ( ) PROVIDER ( ) MEMBER

CAT.	DIST.	PROC.CODE	QTY.	EXCL.	C.O.B.	COM.