Medical Claim Form

Why is this form used?
Alliant Health Plans members may use the Medical Claim Form to file a claim for any medical services received from Out of Network providers. In Network providers are required to file claims on behalf of members.
(Note: This form is not to be used for Pharmacy claims. Pharmacy claims should be submitted using the "Prescription Drug Claim Form" which is available at AlliantPlans.com.)

Did you know?
Alliant has a robust network of over 18,000 providers. You receive more comprehensive benefits and may experience a lower cost share if you choose an In Network provider. This can be especially cost effective when receiving ongoing services. Please visit the Alliant Health Plans website to verify a provider's network participation or contact Customer Service at 800-811-4793.

Things to Remember:

- Accurately complete this form. Be sure information is clear and includes the following:
  - Member ID
  - Provider Tax ID
  - Provider Phone #
- Send a detailed claim of the services received from your provider, not just a receipt of your payment. Detailed claim should include the following:
  - Patient Name
  - Date of Service
  - Type of Service/Procedure Codes
  - Diagnosis Codes
- Complete a separate form for each patient and/or each provider.
- Be sure to maintain a copy of the Medical Claim Form, claim details and receipts for your records.
- Send the claim as soon as possible. You have 90 days from the date of service to submit a properly completed claim form with any necessary reports and records.
- Submit your claim to one of the following:

  Mail: Alliant Health Plans
  PO Box 3708
  Corpus Christi, TX 78463
  Email: customerservice@AlliantPlans.com
  Fax: 866-634-8917

What happens next?
An Explanation of Benefits (EOB) will be produced when the claim has been processed. The EOB will explain how your claim was processed and inform you of charges applied to your deductible (the amount you pay for covered services before your plan begins to pay) and any other charges you may owe your provider. Copies of EOBs can be found on PHRAnywhere.

MEDICAL CLAIM FORM

Direct Member Reimbursement Request

This form is to be used for Out of Network medical claims only. Complete all fields and submit an itemized bill with the form for prompt and accurate processing. See page 1 for a list of all required information and form instructions.

SUBSCRIBER INFORMATION

Subscriber Name:	
Subscriber ID Number:	Date of Birth: MM/DD/YYYY
Subscriber Address:	
Subscriber Phone Number:	Subscriber Email:

PATIENT INFORMATION If different than subscriber

Patient Name:	
Date of Birth: MM/DD/YYYY	Patient Phone Number:
Patient Address:	

OTHER INSURANCE INFORMATION If this does not apply, check "No" and skip section

Is the patient covered by another insurance plan? ☐ Yes ☐ No	
Name of Other Insurance Carrier:	
Policyholder's Date of Birth: MM/DD/YYYY	ID Number:

PROVIDER INFORMATION

Provider Name:	Provider Tax ID Number:
Provider Address:	
Provider Phone Number:	

ACCIDENT INFORMATION If this does not apply, check "No" and skip section

Was this an accident? ☐ Yes ☐ No

Type of accident? ☐ Work ☐ Auto ☐ Other

Date of Accident: MM/DD/YYYY

Please explain how the accident occurred:

ASSIGNMENT OF BENEFITS If not checked, please include proof of payment

☐ Please check box if you want Alliant Health Plans to pay benefits directly to the provider.

By signing below, I am stating that the information above is correct and complete. Any misrepresentation, false or misleading information will result in denial of claim and may result in criminal investigation.

Subscriber Signature _____ Date _____

Important: Claims cannot be processed until this form is properly completed and received. See page 1 for more instructions.
If you require assistance, contact Customer Service at 800-811-4793.

Return this form, itemized statement and any proof of payment to Alliant Health Plans.

Mail: Alliant Health Plans
PO Box 3708
Corpus Christi, TX 78463
Email: customerservice@AlliantPlans.com
Fax: 866-634-8917

Language Assistance

Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de Alliant Health Plans, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al (800) 811-4793.

Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Alliant Health Plans, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi (800) 811-4793.

만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 Alliant Health Plans 에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는(800) 811-4793 로 전화하십시오.

如果您，或是您正在協助的對象，有關於[插入SBM項目的名稱Alliant Health Plans]方面的問題，您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥電話 [在此插入數字 (800) 811-4793。

તમને વિના મૂલ્યે તમારી ભાષામાં મદદ અને માહિતી મેળવવાનો અધિકાર છે. આરોગ્ય વીમા વ્યાપારબજાર વિશે દુભાષિયા સાથે ગુજરાતીમાં વાતચીત કરવા, કૉલ કરો (800) 811-4793.

Si vous, ou quelqu'un que vous êtes en train d'aider, a des questions à propos de Alliant Health Plans, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez (800) 811-4793.

እርስዎ፣ ወይም እርስዎ የሚረዱት ሰው ስለAlliant Health Plans ጥያቄ ካላቸው፣ ያለ ምንም ክፍያ በቋንቋዎ እርዳታና መረጃ የማግኘት መብት አላቸው። ከአስተርጓሚ ጋር ለመነጋገር፣ (800) 811-4793 ይደውሉ።

यदि आपके ,या आप द्वारा सहायता ककए जा रहे ककसी व्यक्तत के Alliant Health Plans के बारे में प्रश्न हैं ,तो आपके पास अपनी भाषा में मुफ्त में सहायता और सूचना प्राप्त करने का अधिकार है। ककसी भाषषए से बात करने के लिए, (800) 811-4793 पर कॉ करें।

Si oumenm oswa yon moun w ap ede gen kesyon konsènan Alliant Health Plans, se dwa w pou resevwa asistans ak enfòmasyon nan lang ou pale a, san ou pa gen pou peye pou sa. Pou pale avèk yon entèprèt, rele nan (800) 811-4793.

Если у вас или лица, которому вы помогаете, имеются вопросы по поводу Alliant Health Plans, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону (800) 811-4793.

إذا كان لديك أو لدى شخص تقدم له المساعدة أسئلة بخصوص Alliant Health Plans، فلديك الحق في الحصول على المساعدة والمعلومات اللازمة بلغتك دون أي تكلفة. للتحدث مع مترجم فوري، اتصل بالرقم (800) 811-4793.

Se você, ou alguém a quem você está ajudando, tem perguntas sobre o Alliant Health Plans, você tem o direito de obter ajuda e informação em seu idioma e sem custos. Para falar com um intérprete, ligue para (800) 811-4793.

اگر آپ ، یا وہ شخص جس کی آپ مدد کر رہے ہیں ، کو Alliant Health Plans، کے بارے میں سوالات درکار ہیں تو آپ کو حق حاصل ہے کہ آپ اپنی زبان میں بغیر کسی لاگت کے مدد اور معلومات حاصل کریں۔ ترجمان سے بات کرنے کے لیے (800) 811-4793. پر کال کریں

Falls Sie oder jemand, dem Sie helfen, Fragen zum Alliant Health Plans haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer (800) 811-4793 an.

ご本人様、またはお客様の身の回りの方でも Alliant Health Plans についてご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合、(800) 811-4793までお電話ください。

TTY/TDD

ATTENTION: If you speak Spanish, language assistance services, free of charge, are available to you. Call 1-(800) 811-4793 (TTY/TDD: 1-(800) 811-4793).

Non Discrimination

Alliant Health Plans complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Alliant Health Plans does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Alliant Health Plans cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo.

Alliant Health Plans tuân thủ luật dân quyền hiện hành của Liên bang và không phân biệt đối xử dựa trên chủng tộc, màu da, nguồn gốc quốc gia, độ tuổi, khuyết tật, hoặc giới tính.

Alliant Health Plans 은(는) 관련 연방 공민권법을 준수하며 인종, 피부색, 출신 국가, 연령, 장애 또는 성별을 이유로 차별하지 않습니다.

Alliant Health Plans 遵守適用的聯邦民權法律規定，不因種族、膚色、民族血統、年齡、殘障 或性別而歧視 任何人。

Alliant Health Plans લાગુ પડતા સમવાયી નાગરિક અધિકાર કાયદા સાથે સુસંગત છે અને જાતિ, રંગ, રાષ્ટ્રીય મૂળ, ઉંમર, અશક્તતા અથવા લિંગના આધારે ભેદભાવ રાખવામાં આવતો નથી.

Alliant Health Plans respecte les lois fédérales en vigueur relatives aux droits civiques et ne pratique aucune discrimination basée sur la race, la couleur de peau, l'origine nationale, l'âge, le sexe ou un handicap.

Alliant Health Plans የፌደራል ሲቪል መብቶችን መብት የሚያከብር ሲሆን ሰዎችን በዘር፡ በቆዳ ቀለም፣ በዘር ሃረግ፣ በእድሜ፣ በአካል ጉዳት ወይም በጾታ ማንኛውንም ሰው አያገልም።

Alliant Health Plans लागू होने योग्य संघीय नागरिक अधिकार क़ानून का पालन करता है और जाति, रंग, राष्ट्रीय मूल, आयु, विकलांगता, या लिंग के आधार पर भेदभाव नहीं करता है।

Alliant Health Plans konfòm ak lwa sou dwa sivil Federal ki aplikab yo e li pa fè diskriminasyon sou baz ras, koulè, peyi orijin, laj, enfimite oswa sèks.

Alliant Health Plans соблюдает применимое федеральное законодательство в области гражданских прав и не допускает дискриминации по признакам расы, цвета кожи, национальной принадлежности, возраста, инвалидности или пола.

Alliant Health Plans يلتزم الأصل الوطني أو السن أو الإعاقة أو الجنس.

Alliant Health Plans cumpre as leis de direitos civis federais aplicáveis e não exerce discriminação com base naraça, cor, nacionalidade, idade, deficiência ou sexo.

Alliant Health Plans و کند می تبعیت مربوطه فدرال مدنی حقوق قوانین از جنسیت یا ناتوانی سن، ملیتی، اصلیت پوست، رنگ نژاد، اساس بر تبعیضی هیچگونه شود نمی قایل افراد.

Alliant Health Plans erfüllt geltenden bundesstaatliche Menschenrechtsgesetze und lehnt jegliche Diskriminierung aufgrund von Rasse, Hautfarbe, Herkunft, Alter, Behinderung oder Geschlecht ab.

Alliant Health Plansは適用される連邦公民権法を遵守し、人種、肌の色、出身国、 年齢、障害または性別 に基づく差別をいたしません。