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 NPI #
  - Provider Phone #
- Send a detailed claim of the services you received from your provider and, if applicable, receipt of payment. Detailed claim should include the 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 180 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 2667
  Dalton, GA 30722
  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 the Member Portal.

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 NPI Number:
Provider Address:		
Provider Phone Number:		

Date of Service: MM/DD/YYYY	Type of Service/Procedure Codes:	Diagnosis Codes:

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

☐ Pleasecheck 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.

☐ As an individual with the capacity to provide consent, my typed full name below constitutes my signature and is intended to be binding.

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 (866) 403-2785.

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

Mail: Alliant Health Plans
PO Box 2667
Dalton, GA 30722
Email: CustomerService@AlliantPlans.com
Fax: (866) 634-8917

Notice of 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:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact **Customer Service at (866) 403-2785.**

If you believe that Alliant Health Plans has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Sabrina LeBeau, Compliance Officer, PO Box 1128, Dalton GA 30722, Ph: (706) 237-8802 or (888) 533-6507 ext 125, Fax: (706) 229-6289, Email: Compliance@AlliantPlans.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Sabrina LeBeau is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Language Assistance

English
ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-866-403-2785 (TTY: 711).

Español (Spanish)
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-866-403-2785 (TTY: 711).

Tiếng Việt (Vietnamese)
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-866-403-2785 (TTY: 711)

한국어 (Korean)
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-866-403-2785 (TTY: 711)번으로 전화해 주십시 h 오.

繁體中文 (Chinese)
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-866-403-2785（TTY：711）。

ગુજરાતી (Gujarati)
સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-866-403-2785 (TTY: 711).

Français (French)
ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-866-403-2785 (ATS : 711).

አማርኛ (Amharic)
ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-866-403-2785 (መስማት ለተሳናቸው: 711).

हिंदी (Hindi)
ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-866-403-2785 (TTY: 711) पर कॉल करें।

Kreyòl Ayisyen (French Creole)
ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-866-403-2785 (TTY: 711).

Русский (Russian)
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-866-403-2785 (телетайп: 711).

العربية (Arabic)
ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-866-403-2785 (رقم هاتف الصم والبكم: (711 TTY).

Português (Portuguese)
ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-866-403-2785 (TTY: 711).

فارسی (Farsi)
توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-866-403-2785 (TTY: 711) تماس بگیرید.

Deutsch (German)
ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-866-403-2785 (TTY: 711).

日本語 (Japanese)
注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-866-403-2785 （TTY:711）まで、お電話にてご連絡ください。