

# Prominence

## Administrative Services

## MEDICAL / DENTAL CLAIM FORM

Please complete this form and attach any itemized bill.

Mail to: Prominence Administrative Services  
 PO BOX 981732, El Paso, TX 79998-1732

**Fax to:** 775-770-9363

**Email to:** [PHPMemberServices@uhsinc.com](mailto:PHPMemberServices@uhsinc.com)

<b>PLEASE CHECK ONE:</b>		
<input type="checkbox"/> MEDICAL	<input type="checkbox"/> DENTAL	<input type="checkbox"/> VISION

### PLEASE FILL OUT THE FOLLOWING INFORMATION

EMPLOYEE NAME		SOCIAL SECURITY #	EMPLOYEE BIRTHDATE	PHONE NO.
MAILING ADDRESS			CITY / STATE	ZIP
PATIENT NAME (IF OTHER THAN EMPLOYEE)		<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	RELATIONSHIP TO EMPLOYEE	PATIENT BIRTHDATE
			IS PATIENT MARRIED? <input type="checkbox"/> YES <input type="checkbox"/> NO	
IS PATIENT FULL TIME STUDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	NAME & ADDRESS OF SCHOOL		DATE ACCIDENT OR SICKNESS BEGAN	
IF INJURED, HOW AND WHERE DID THE ACCIDENT HAPPEN?			DID THE ACCIDENT HAPPEN AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	HAS A CLAIM BEEN FILED WITH WORKER'S COMP? <input type="checkbox"/> YES <input type="checkbox"/> NO
NATURE OF SICKNESS, INJURY OR DIAGNOSIS			PHYSICIAN'S NAME	
NAME OF SPOUSE	BIRTHDATE	IS SPOUSE EMPLOYED? <input type="checkbox"/> YES <input type="checkbox"/> NO	NAME & ADDRESS OF SPOUSE'S EMPLOYER	

ARE YOU, THE PATIENT OR SPOUSE, COVERED UNDER ANY OTHER GROUP HEALTH PLAN, HEALTH MAINTENANCE ORGANIZATION, GOVERNMENT PLAN, OR INSURANCE POLICY WHICH WILL ALSO PAY FOR THE EXPENSES OF THIS CLAIM?  YES  NO IF YES, PLEASE COMPLETE THE SECTION BELOW

POLICY HOLDER: _____	SOCIAL SECURITY NO.: _____
NAME AND ADDRESS: _____	POLICY NO.: _____
_____	EFFECTIVE DATE: _____

#### PATIENT OR PARENT MUST SIGN BELOW

#### IF PAYMENT IS TO BE MADE TO PROVIDER, SIGN BELOW

<b>AUTHORIZATION TO RELEASE INFORMATION</b> I hereby authorize any insurance company, prepayment organization, employer, hospital, or physician, to release all information with respect to myself or any of my dependents which may have a bearing on the benefits payable under this or any other plan providing benefits or services. I hereby certify this information provided is correct and true to the best of my knowledge.	<b>AUTHORIZATION TO PAY BENEFITS DIRECTLY TO PROVIDER(S)</b> I hereby authorize payment of benefits to any provider of services, otherwise payable to me for services, but not to exceed the reasonable and customary charges for those services. I understand that I am financially responsible for any charges not covered by this authorization.
X _____ Date Covered Person	X _____ Date Covered Person

#### PATIENT CLAIM FILING INFORMATION (HOW TO FILE):

Be sure to ask your provider of care if he/she will file a claim with Prominence Administrative Services. Please submit statements only if the provider does not bill us directly. To receive benefits for services by a provider who does not bill us directly, complete this Claim Form, attach itemized bills and a proof of payment (if applicable) and mail to:

**Prominence Administrative Services**  
 PO BOX 981732  
 El Paso, TX 79998-1732

This information also can be faxed to 775-770-9363 or emailed to [PHPMemberServices@uhsinc.com](mailto:PHPMemberServices@uhsinc.com).

Please keep a duplicate copy of your itemized bills and proof of payment as they will not be returned to you. This claim may be returned to you if all required information is not present.

#### REQUIRED INFORMATION FOR ITEMIZED BILLS:

Summarizing the services may help us better understand the attachments if they are not clear. The attached itemized bills must include the provider name, patient's name, date of service, detailed description of service, and amount charged for that service. These must be valid documents from the provider.

If you have questions or need assistance, contact Customer Service at 800-455-4236.