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Salt Lake City, Utah 84145
Telephone 1-801-578-5600 • Toll Free 1-800-777-3622
Fax Number 1-801-578-5903 • Web site: www.dmba.com

CLAIMS OFFICE USE ONLY

MEDICAL CLAIM FORM

AVOID DELAY – ANSWER ALL QUESTIONS (INSTRUCTIONS ON BACK)

NAME OF INSURED		DESERET MUTUAL ID NO.	NAME OF EMPLOYER		INSURED'S BIRTHDATE	
NAME OF SPOUSE		DESERET MUTUAL ID NO.	SPOUSE'S EMPLOYER – IF NOT EMPLOYED, CHECK HERE <input type="checkbox"/>		SPOUSE'S BIRTHDATE	
NAME OF PATIENT	PATIENT'S RELATIONSHIP TO INSURED: <input type="checkbox"/> SELF <input type="checkbox"/> NATURAL CHILD <input type="checkbox"/> SPOUSE <input type="checkbox"/> OTHER _____	IF CHILD, IS HE/SHE EMPLOYED? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, WHERE?	IF CHILD, IS HE/SHE MARRIED? <input type="checkbox"/> YES <input type="checkbox"/> NO	PATIENT'S BIRTHDATE		
NAME OF PHYSICIAN		DESCRIBE THE SICKNESS OR INJURY				
DATE OF ACCIDENT OR DATE SICKNESS BEGAN MO. DAY YR.		IF INJURED, HOW DID THE ACCIDENT HAPPEN?				
IF INJURED, WHERE DID THE ACCIDENT HAPPEN?			WAS THE CONDITION RELATED IN ANY WAY TO: A. PATIENT'S EMPLOYMENT? <input type="checkbox"/> YES <input type="checkbox"/> NO B. AN AUTOMOBILE <input type="checkbox"/> YES <input type="checkbox"/> NO			
IS THERE SOMEONE ELSE (A THIRD PARTY, ETC.) WHO MAY BE LIABLE TO PAY FOR THE CLAIMED MEDICAL EXPENSES? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE NAME AND ADDRESS.						
IS THE PATIENT COVERED BY ANY OTHER GROUP INSURANCE, HEALTH MAINTENANCE ORGANIZATION, OR GOVERNMENT PLAN (INCLUDING MEDICARE)? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, PLEASE STATE: <ul style="list-style-type: none"> • THE NAME OF THE INSURANCE COMPANY OR OTHER PROVIDER OF BENEFITS _____ • THE INSURED INDIVIDUAL'S NAME _____ • THE INSURED INDIVIDUAL'S SOCIAL SECURITY NUMBER _____ • THE NAME OF THE GROUP POLICYHOLDER AND CONTRACT NUMBER(S) _____ • THE ADDRESS OF THE INSURANCE COMPANY OR OTHER PROVIDER OF BENEFITS _____ • THE PHONE NUMBER OF THE INSURANCE COMPANY OR OTHER PROVIDER OF BENEFITS _____ 						
INSURED'S CURRENT MAILING ADDRESS AS OF _____ DATE			PLEASE SIGN BELOW			
STREET			I CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND COMPLETE. I AUTHORIZE DESERET MUTUAL, AND/OR PROVIDERS OF HEALTH CARE, AND/OR PERSONS OR ENTITIES RETAINED BY DESERET MUTUAL FOR THE PURPOSE OF AUDITING CLAIMS, TO SECURE OR RELEASE INFORMATION RELATING TO THIS CLAIM. I UNDERSTAND, AGREE, AND CONSENT THAT THIS AUTHORIZATION SHALL REMAIN IN EFFECT INDEFINITELY.			
CITY		STATE				ZIP
HOME PHONE NUMBER ()	WORK PHONE NUMBER ()					SIGNATURE _____
PAYMENT METHOD						
DO YOU WISH PAYMENT TO BE MADE DIRECTLY TO THE PROVIDER, HOSPITAL, PHYSICIAN, ETC.? <input type="checkbox"/> YES <input type="checkbox"/> NO						
DO YOU WISH PAYMENT TO BE MAILED DIRECTLY TO YOU? <input type="checkbox"/> YES <input type="checkbox"/> NO						
MANAGEDCARE: IF PROVIDER IS A PRIMARY CARE PHYSICIAN OR A CONTRACT SPECIALIST, PAYMENT WILL BE MADE DIRECTLY TO THE PROVIDER.						
REMEMBER – YOU MUST BE REFERRED BY YOUR PCP BEFORE SEEING ANOTHER PHYSICIAN OR PROVIDER. ANY MEDICAL, HOSPITAL, OR OTHER HEALTH CARE RECEIVED WITHOUT PRIOR COORDINATION WITH YOUR PCP WILL NOT BE COVERED BY THE PLAN.						
NAME OF PATIENT'S PCP			NAME OF SPECIALIST OR OTHER PROVIDER			
DESERET MUTUAL USE ONLY						

HELP US PROCESS YOUR CLAIM

1. A claim form, properly *completed and signed*, is required for each illness or accident and must be included each time you submit a bill.
2. Attach a complete itemized bill from the provider of services. An itemized bill includes:
 - diagnosis and diagnostic code(s)
 - procedure(s) and procedure code(s)
 - place of service
 - amount charged for each service
 - provider name, address, phone number, and tax identification number.
3. **MEDICARE PARTICIPANTS** – To claim benefits supplemental to those paid by Medicare, you must *first* file your claim with Medicare. After you receive the “Medicare Summary” Notice statement from Medicare, you may then file with Deseret Mutual for possible additional benefits. When filing such a claim, *always* attach the “Medicare Summary Notice” statement and a copy of the itemized bill to your claim form.
4. **COORDINATION OF BENEFITS** – When you or your dependents are covered by more than one group medical plan, benefits may be coordinated, with possible payment of benefits from both sources. (Your Benefits Handbook explains Coordination of Benefits in detail.) When you complete the section on this form giving us the information on your other medical plan, Deseret Mutual will contact them and provide the service of coordinating benefits for your maximum eligible benefit coverage.
5. Claims **must be submitted within 15 months** from the date the service was rendered. Claims received after this date will not be eligible for benefits.
6. Send the claim form and related medical bills to:

Deseret Mutual
P.O. Box 45530
Salt Lake City, Utah 84145

When the claim has been processed, you will receive an Explanation of Benefits from Deseret Mutual, verifying payment and explaining how your claim has been handled. If you have any questions, please contact Deseret Mutual at the address above or call:

Salt Lake City, Utah Area 1-801-578-5600
Toll Free 1-800-777-3622
In Hawaii 1-808-293-3970

NOTE: Be sure to fill in **all** of the requested information. If you fail to do so, processing your claim may be delayed.