MEMBER *Claim Submission* FORM

Please complete the entire form and attach/include as much information as possible.

PATIENT INFORMATION

Name (LAST, FIRST MI)		ID Number		Employee Name	
Date of Birth (PATIENT)	Street Address	City	State	Zip Code	

CLAIM INFORMATION

Diagnosis	Diagnosis Code

Date of Service	Description of Service (INCLUDING PROCEDURE CODES)	Charge Amount

PHYSICIAN INFORMATION

Name of Physician or Facility		Tax ID Number		
Phone Number	Street Address	City	State	Zip Code

IMPORTANT NOTE: Your bill and/or receipt *must* accompany this form for processing. Please remember to attach your ***itemized bill*** for reimbursement consideration.

PATIENT'S SIGNATURE: _____ DATE _____

Please return this form and supporting documentation to:

Kentucky Health Administrators
Attn: Member Claim Submissions
2331 Fortune Drive, Suite 185
Lexington, KY 40509

FAX (630) 206 - 1055 | EMAIL claims@kyhealthadmin.com