INDECS CORPORATION
1099 Wall Street W., PO Box 668
Lyndhurst, NJ 07071-0668
1 (888) 4-INDECS (446-3327)
Claims Services Fax (201) 460-3205

Print Form

INSTRUCTIONS FOR FILING A CLAIM

A separate claim is required for each patient for whom a claim is made. Members should **NOT** pay PPO Network Providers.

This form cannot be emailed - complete all items before printing!

A. Please be sure that all information requested on the claim form is fully completed. Claims that are incomplete will be delayed and may have to be returned unprocessed.
B. If you wish payment to be made directly to the physician or supplier of service, complete the appropriate "assignment", item 13. If there is not sufficient room, write on the bill "Pay Provider Directly", date and sign your name. Assignments without signature may not be valid.
C. All itemized bills must include the following: 1-Name of patient 2-Date of service 3-Type and CPT code for each service 4-Nature of illness or injury (diagnosis) 5- amount.
D. Mail to INDECS at the above PO Box address, or fax to claim services.

Note: Receipts, balance due statements, EOB statements from other carriers or cancelled checks are not acceptable as itemized bills.

TO BE COMPLETED BY MEMBER

IMPORTANT NOTICE: ITEMS 1-13 MUST BE COMPLETED IN FULL FOR EACH CLAIM. PRINT FORM, THEN SIGN ITEM 12 AND ITEM 13 IF YOU WANT BENEFITS PAID TO PROVIDER(S).

1 a) Name of Employee/Plan Member (First, MI, Last) _____ b) SSN _____

2 a) This Claim is for: (First, MI, Last, Name if Different): _____ b) Claimant's Sex ☐ M ☐ F c) DOB _____

3 a) Name of Member's Employer _____

MEMBER'S STATUS

a) ☐ Married ☐ Single ☐ Divorced ☐ Separated | c) Birth Date _____ | d) ☐ M ☐ F | e) ☐ Active ☐ Retired ☐ COBRA

4 a) Member's Home Address: Street _____ City _____ State _____ Zip Code _____ b) Is this a new address? ☐ Yes ☐ No

5 a) Claim is for: ☐ Member/Employee ☐ Spouse ☐ Child ☐ Other If Other, Explain: _____ b) Claimant's Employer: _____

6 a) Is Claimant eligible for Medicare? ☐ Yes ☐ No If Yes, Effective Date: Mo. ☐☐ Yr. ☐☐ | b) Is Claimant handicapped? ☐ Yes ☐ No | c) Is Claimant full-time student over age 19? ☐ Yes ☐ No

7 a) If Student is over age 19, name of school presently attending: _____ Street _____ City _____ State _____ Zip Code _____

8 a) Is the Member, Spouse or Dependent Child entitled to Benefits from any other kind of Group Health Insurance or Plan? ☐ Yes ☐ No

IF YES: name and birthday of person with other coverage:

NAME _____ DOB _____

And Complete 8b-g regarding other coverage.

b) Is the Person in 8 employed? ☐ Yes ☐ No If Yes, give Employer's full name & address: _____

c) Name & Address of other Insurance Company or Organization where claims are submitted: _____ | d) Effective Date _____

e) Relationship to Member ☐ Self ☐ Spouse ☐ Child ☐ Other | f) Group Policy/Contract # _____ | g) SSN/ID # _____

9 a) Diagnosis or Nature of Illness or Injury for which claim is made: _____ b) Date first treated for this Condition: _____ c) Is this Condition due to an Occupational Injury or Disease? ☐ Yes ☐ No

10 a) Is claim based on an accident? ☐ Yes ☐ No | b) Did accident happen while working? ☐ Yes ☐ No | c) Auto Accident? ☐ Yes ☐ No | d) Other ☐ Yes ☐ No | e) Date of Accident _____

11 **IF Yes** in Section 10, how and where did accident happen: _____

12 **Must be signed here**

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize INDECS Corp. to release or obtain any information which may be necessary to determine benefits payable under the Group Plan. A photocopy of this authorization shall be valid. I certify to the truth of the answers on this form, knowing that false or fraudulent information is punishable under the law.

Member's Signature: _____ Claimant (if adult): _____ Date: _____

13 SIGN FOR BENEFITS TO BE PAID TO PROVIDER

ASSIGNMENT: I authorize and request that payment be made directly to the following provider(s). **I understand that I am financially responsible for charges not paid by this assignment: (see filing instruction B, if more than 3 assignments.)**

☐ **YES;** TO: 1. _____ 2. _____

or

☐ **NO, DO NOT PAY PROVIDER(S)** *(Note: PPO Network Providers MUST be paid by Plan.)* 3. _____

Member's Signature: _____ Date _____

ARE ITEMIZED BILLS* ENCLOSED?

***An itemized bill is one that shows the patient's name, relationship, date of service, the type, and CPT code for each service rendered, the nature of the condition (diagnosis) being treated, amount of charge for each service or supply (must be itemized) and provider's tax identification number.**

FOR CLAIMS OR COVERAGE INFORMATION CALL: 1-888-4INDECS (446-3327)