Member Claim Form

Please print using black ink. Initial all corrections.

All questions must be answered.

Each item on this form is required to be completed. Instructions are listed below.

This form is for Evry Health, health insurance claims ONLY, to ask for payment for eligible health care services from a non-participating provider you have received and paid for.

If you write on the form, use black ink, and print clearly and legibly. You can also use your computer to complete this form and then print it out. Ask your provider for the Provider Information or have them fill that out for you. Be sure to submit a separate form for each claim. Complete all applicable fields on the form and include proof of payment. Mail all documentation to:

Evry Health
PO BOX 571208
Dallas, TX 75357

If you have other insurance or Medicare and it is primary to your Evry Health plan, please include the explanation of benefit s (EOB) from your other insurance or Medicare.
Your claim reimbursement request must be filed within 120 days (four months) from the date of occurrence.

Get a detailed itemized bill for each time you received care and include it with this completed form.

IMPORTANT: This is required information. Missing information can result in a delay or non-payment of the claim.

- Patient Name.
- Date(s) of service.
- Diagnosis codes.
- Procedure Codes (CPT, HCPC) - with any applicable modifiers.
- Units for each procedure code.
- The billed amount for each procedure code.
- Place of service code.

Did you check the provider directory?

To avoid paying out of pocket for medical services received, access the Evry provider directory to locate a participating provider. If you need assistance in locating a provider, please call Member Services at 855-579-3879.
Please review your benefits at evryhealth.com. For services that require prior authorization or notification, be sure to call the Member Services number.

What happens next:

Claim reimbursement will be sent to the Evry member who submitted the claim form. Please note that reimbursement for a claim rendered to an underage child will be sent to the Evry policyholder. After we process your claim, we will send you an Explanation of Benefits (EOB). The EOB will explain the charges applied to your plan deductible and any charges you owe your health care provider. Please keep your EOB on file for future reference. You also may review your EOB information online at https://portal.evryhealth.com/.

Once you have completed the form, mail it to the address listed on the back of your Health Plan ID Card. Be sure to attach the itemized bill and any receipts of your payments.

Evry Health
A Globe Life Company

Medical Claim Form

for large employer groups

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Group Number	
Patient Information. (Last, First, Middle)	
Gender	**Date of Birth** ____/____/____ Month Day Year
Relationship to Policyholder/Subscriber? ☐ Self ☐ Spouse ☐ Child ☐ Other (explain) _____	

Policyholder Information. (Last, First, Middle Initial)	
Home Address	
City and State	**ZIP Code**
New Address? ☐ Yes ☐ No	

Provider Information. This information is required to process the claim. Ask your provider for this information or have them fill it out for you.

Provider or Rending Provider Name	**Provider Tax Identification Number**	**NPI Number**
Group/Facility Name	**Provider Address**	
Address where services were rendered (City, State, Zip code)		

Accident Information (if applicable)

Date of accident	**Type of accident** ☐ Work ☐ Auto ☐ Other	**How did this accident happen?**

Other Insurance if applicable)

Is the patient covered by another insurance plan? ☐ Yes ☐ No (If yes please complete the following information.)	**Policyholder Information.** (Last, First, Middle Initial)	**Date of Birth** ____/____/____ Month Day Year
Name of Other Insurance Carrier	**Policy Number:**	**Policy Number**
Effective Date of Other Insurance ____/____/____ Month Day Year	**Cancellation date of other insurance** (if applicable) ____/____/____ Month Day Year	**Did you attach an EOB from Medicare or other insurance?** ☐ Yes ☐ No

Assignment of Benefits.

☐ **Please check this box if you want Evry Health to pay benefits directly to the doctor/provider.**

By signing below, I am stating that the information above is correct. Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete, or misleading information, may be guilty of a criminal act punishable under law and may be subject to civil penalties.

Print Name	
Signature	**Date**

Itemized bill(s) for covered services and supplies with evidence of payment must be attached.