PLEASE
DO NOT
STAPLE
IN THIS
AREA

MEDICAL MUTUAL OF OHIO
Your healthcare partner since 1934

CARRIER

HEALTH INSURANCE CLAIM FORM

PICA ☐☐☐ PICA

1 MEDICARE ☐ (Medicare #) MEDICAID ☐ (Medicaid #) CHAMPUS ☐ (Sponsor's SSN) CHAMPVA ☐ (VA File #) GROUP HEALTH PLAN ☐ (SSN or ID) FECA BLK LUNG ☐ (SSN or ID) OTHER ☐ (ID)

1a INSURED'S ID NUMBER (FOR PROGRAM IN ITEM 1)

2 PATIENT'S NAME (Last Name First Name Middle Initial)

3 PATIENT'S BIRTH DATE MM DD YY SEX M ☐ F ☐

4 INSURED'S NAME (Last Name First Name Middle Initial)

5 PATIENT'S ADDRESS (Street No)

6 PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐

7 INSURED'S ADDRESS (Street No)

CITY STATE

8 PATIENT STATUS Spouse ☐ Married ☐ Other ☐
Employed ☐ Full-Time Student ☐ Part-Time Student ☐

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (INCLUDE AREA CODE) ( )

9 OTHER INSURED'S NAME (Last Name First Name, Middle Initial)

10 IS PATIENT'S CONDITION RELATED TO:

11 INSURED'S POLICY GROUP OR NUMBER

a OTHER INSURED'S POLICY OR GROUP NUMBER

a EMPLOYMENT? (CURRENT OR PREVIOUS) ☐ YES ☐ NO

a INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b AUTO ACCIDENT? PLACE (State) ☐ YES ☐ NO

b EMPLOYER'S NAME OR SCHOOL NAME

c EMPLOYER'S NAME OR SCHOOL NAME

c OTHER ACCIDENT? ☐ YES ☐ NO

c INSURANCE PLAN NAME OR PROGRAM NAME

d INSURANCE PLAN NAME OR PROGRAM NAME

10d RESERVED FOR LOCAL USE

d IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO *If yes,* return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12 PATIENT S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any medical or other information necessary to process this claim I also request payment of government benefits either to myself or to the party who accepts assignment below

SIGNED ______ DATE ______

13 INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below

SIGNED ______

PATIENT AND INSURED INFORMATION

14 DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15 IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE MM DD YY

16 DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17 NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. ID NUMBER OF REFERRING PHYSICIAN

18 HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY

19 RESERVED FOR LOCAL USE

20 OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES

21 DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (RELATE ITEMS 1 2 3 OR 4 TO ITEM 24E BY LINE)

1 ______ 3. ______
2 ______ 4 ______

22 MEDICAID RESUBMISSION CODE ORIGINAL REF NO

23 PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS | MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1										
2										
3										
4										
5										
6										

PHYSICIAN OR SUPPLIER INFORMATION

25 FEDERAL TAX ID NUMBER SSN ☐ EIN ☐

26. PATIENT'S ACCOUNT NO

27 ACCEPT ASSIGNMENT? ☐ YES ☐ NO

28 TOTAL CHARGE $

29 AMOUNT PAID $

30 BALANCE DUE $

31 SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof)

SIGNED DATE

32 NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33 PHYSICIANS SUPPLIERS BILLING NAME ADDRESS ZIP CODE & PHONE #

PIN# GRP#

PLEASE PRINT OR TYPE

SC37 R12/04

ATTENTION PROVIDER — FOR FASTER CLAIM PROCESSING REMEMBER:

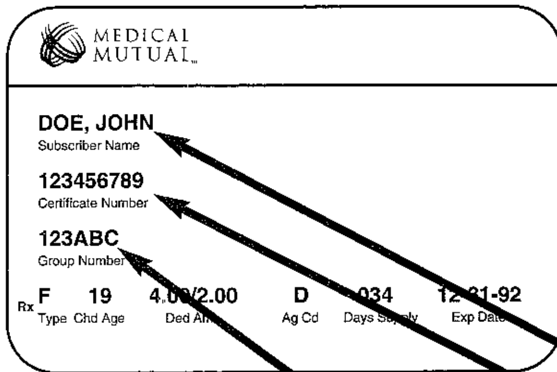
- The Insured's certificate number (Item #1a) is critical to the timely and accurate processing of this claim. Remember to include any Alphabetic characters which may precede the certificate number
- The patient's birth date must be listed. (Item #3)
- The insured's full address and zip code are required (Item #7)
- Onset date must be completed (Item #14)
- Diagnosis codes (Items #21 and 24E) and procedure codes (Item #24D) are required
- The Provider/Supplier SSN or Tax ID # must be completed (Item #25 or 33)
- SUPER BILLS SLOW DOWN CLAIM PROCESSING
- ELECTRONIC CLAIMS SUBMISSION SPEEDS CLAIMS PAYMENT

PLACE OF SERVICE CODES:

41 – Ambulance
42 – Ambulance-Air/Water
24 – Ambulatory Surgical Center
25 – Birthing Center
53 – Community Mental Health Center
61 – Comprehensive Inpatient Rehab Facility
62 – Comprehensive Outpatient Rehab Facility
33 – Custodial Care
52 – Day Care/Psy. Part Hosp
11 – Doctor's Office
23 – Emergency Room Hospital
34 – Hospice
65 – Independent Kidney Disease Treatment Center
81 – Independent Laboratory
21 – Inpatient Hospital
51 – Inpatient Psych. Facility
26 – Military Treatment Facility
32 – Nursing Care
99 – Other Locations
22 – Outpatient Hospital
12 – Patient s Home
56 – Residential Treatment Center
72 – Rural Health Clinic
31 – Skilled Nursing Facility
54 – Specialized/Intermed./Mental TC
71 – State or Local Public Health Clinic

TYPE OF SERVICE CODES:

1 – Medical Care
2 – Surgery
3 – Consultation (Inpatient only)
4 – Diagnostic X-Ray
5 – Diagnostic Laboratory
6 – Radiation Therapy
7 – Anesthesia
8 – Assistant at Surgery
9 – Other Medical Service
0 – Blood or Packed Red Cells
A – Used DME
C – Inpatient Psychiatric Services
F – Ambulatory Surgical Center
G – Purchased DME
H – Hospice
H – Rental DME
L – Renal Supplies in the Home
M – Alternate Payment for Maintenance Dialysis
M – Vision Care
N – Kidney Donor
V – Pneumococcal Vaccine
V – Hearing Care
Y – Second Opinion on Elective Surgery
Z – Third Opinion on Elective Surgery



ALL Claims should be forwarded to:

Medical Mutual
P.O. Box 6018
Cleveland, OH 44101-1018

PLEASE DO NOT STAPLE IN THIS AREA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) CHAMPUS (Sponsor's SSN) CHAMPVA (VA File #) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN or ID) OTHER (ID) | 1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) | 3. PATIENT'S BIRTH DATE MM DD YY SEX M F | 4. INSURED'S NAME (Last Name, First Name, Middle Initial)
5. PATIENT'S ADDRESS (Street No.) | 6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other | 7. INSURED'S ADDRESS (Street No.)
CITY STATE | 8. PATIENT STATUS Spouse Married Other | CITY STATE
ZIP CODE TELEPHONE (Include Area Code) ( ) | Employed Full-Time Student Part-Time Student | ZIP CODE TELEPHONE (INCLUDE AREA CODE) ( )
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) | 10. IS PATIENT'S CONDITION RELATED TO: | 11. INSURED'S POLICY GROUP OR NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER | a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO | a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

PATIENT CLAIM FILING INSTRUCTIONS INFORMATION

1. Use this form for filing claims for reimbursement of all eligible Medical and other expenses eligible under MM insurance programs
2. Complete all Items #1-10 and 12 and 13 contained in the Patient and Insured Information section including your signature and date All the information is essential for prompt and accurate processing of your claim(s)
3. If you are submitting the claim, you must either have the provider (physician) of the services complete the Physician/Supplier Information section of this form or submit an itemized statement (which should include the information noted).
4. The form must include name of patient date(s) of service, type of service(s) performed diagnosis charge(s) and date(s) symptom first appeared
5. If the Hospital Physician or other Health Care Provider is submitting the claim the Provider/Supplier should complete Items #14-33.
6. If you are submitting a drug claim be sure to include the prescription drug number and drug name, date of purchase prescribing doctor and amount charged
7. Balance due statements cannot be processed and will be returned We need itemized statements for faster processing and better service
8. Onset date is required (Item #14) otherwise the claim will be returned
9. To ensure receipt of your EOB and/or reimbursement please indicate if there is a change in the insured's mailing address (Item #7)

WARNING: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud. (Ohio Revised Code Section 3999.21)

WARNING: A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony. (Indiana Code IC 27-2-16-3)

Medco Health Home Delivery Pharmacy Service™ Order Form

ZAVIDOW-SHOWS

Benefits Provided by Zavidow-Shows

FOLD BACK HERE

For Refills

To order from our website **www.medcohealth.com** Have your Member ID number and Prescription (Rx) number on hand Your 12-digit Prescription or Rx number can be found on your refill slip

To order by phone Call **1 800 4REFILL** (1 800 473-3455) to use the automated refill system Have your Member ID number and your refill slip with the prescription information ready

To order by mail Include your refill slip(s) with this form Do not complete the Patient Information section for refills

For New Prescriptions

Fill out one line of the Patient Information Section for each new prescription you send Be sure to include the patient's full name, date of birth, and address, along with the doctor's name and phone number

For All Home Delivery Orders

Place all prescriptions and refill slips together with this completed order form and your co-payment in the enclosed return envelope Be sure to fold the form as indicated so the address on the bottom right shows through the window

If You Need Additional Help

Call Member Services at **1 800 251-7690** Best times to call are Tuesday through Friday afternoons

See the back of this form for additional instructions

Member Information

Member ID: ______________________

Group: *ZAVIDOW*

Name: ______________________

Street Address: ______________________

Street Address: ______________________

Street Address: ______________________

City ST, ZIP: ______________________

Daytime telephone ☐☐☐ ☐☐☐ ☐☐☐☐

Evening telephone ☐☐☐ ☐☐☐ ☐☐☐☐

Shipping address if different from your mailing address

Check if ☐ Temporary ☐ Permanent

____

____

____

You authorize release of all information to the plan administrator underwriter, sponsor, policyholder, employer and their agents for use in connection with the benefit plan programs Information may also be used for other reporting and analysis purposes without identification of you or your family members

FOLD BACK HERE

Patient Information—Complete one line for each new prescription *(Do not complete for refills)*

	Patient name and Medicare B number (if applicable)	Patient's relation to plan member *(fill in one)*	Sex	Birth date M/D/YYYY	Doctor name and phone number	Does patient have any other prescription plan?
1		Self ☐ Spouse ☐ Dependent ☐	☐ M ☐ F	/ /		☐ Yes ☐ No
2		Self ☐ Spouse ☐ Dependent ☐	☐ M ☐ F	/ /		☐ Yes ☐ No
3		Self ☐ Spouse ☐ Dependent ☐	☐ M ☐ F	/ /		☐ Yes ☐ No

Order Information

Total number of medications in this order (including all refills and new medications) ☐

Subtotal of this order $ ☐☐☐.☐☐

Optional expedited shipping $9 00 (subject to change) ☐☐.☐☐

Total enclosed (do not send cash) $ ☐☐☐.☐☐

Paying by Credit Card? ☐Visa ☐MC ☐Disc/NOVUS ☐AmEx ☐Diners

☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

CREDIT CARD NUMBER

M ☐☐ Y ☐☐ **X** ______________________

EXPIRATION DATE CARDHOLDER SIGNATURE

☐ **Check here to have all orders billed to your credit card.** By doing so, you authorize Medco Health to keep your card number on file and bill all future orders directly to your credit card To enroll by phone please call 1 800 948-8779

Paying by check? Write your Member ID on your check or money order made payable to Medco Health

MEDCO HEALTH
PO BOX 3938
SPOKANE, WA 99220-3938

FORM #HB903504

Please take a minute to make sure....

- **You have included your doctor's signed prescription form and filled out the patient information on the front of the order form for each new prescription.**
- **You have either filled out the credit card section on the front of this order form or included a check or money order for the required co-payment.**
- **You have written your Member ID on any check or money order.**
- **The Medco Health address on the front shows through the window of the return envelope.**
- **You have filled out the Health, Allergy, and Medication Questionnaire. This information will help Medco Health better serve your prescription drug needs.**

Expedited shipping available

For an additional fee, your order will be shipped by an expedited service offered to your area This option must be chosen when you make the order, and cannot be applied after an order is already processed

Additional Instructions

If you elect to have this and all future orders automatically charged to your credit card by checking the box on the front or enrolling by phone, bear in mind that the automated payment plan feature will apply to all Home Delivery Pharmacy Service orders Also note that we can only keep one credit card on record

You may have a balance limit on your plan account If you do, once your unpaid balance exceeds that limit, no additional orders will be processed until the balance is paid

You can call 1 800 948-8779 anytime to enroll in our automated payment plan, change the credit card on file, check your account balance, or pay by phone using a credit card

State law allows a less expensive, generically equivalent drug to be substituted for certain brand-name drugs unless you or your physician direct otherwise

Get more information from our website

Visit us at **www.medcohealth.com**

Form#HB903504

BOARD OF COMMISSIONERS

Gary W. Bauer
Ralph A. Fegley
Mike Adelman

CLERK
Cheryl Nolan

The first meeting of the Huron County Commissioners was August 1, 1815 with the first three Commissioners being Caleb Palmer, Charles Parker and Eli S. Barnum. The first Clerk was Ichabod Marshall. The first act was to order a schoolhouse converted for Commissioners' meetings. Norwalk became the county seat in 1818 when the number of registered voters was 56 and when the total taxes collected that year was $192.40. Commissioners purchased a building to use as a courthouse in 1818 for $848 and built a new jail for $1,275. Huron County's area was dramatically reduced in 1838 when Erie County was formed. Population in 1900 was were more than 32,000. Today, Huron County boasts more than 59,487 citizens.

Northwest Territory 1787
Firelands Territory 1782
Settled in 1804
Huron County
Founded in 1809

REQUEST FOR EXPENDITURE OF OVER $500.00

DEPARTMENT: ______________________________

DATE: ______________________________

AMOUNT OF REQUEST: ______________________________

FOR: ______________________________

TO: ______________________________

PLEASE PROVIDE A NARRATIVE EXPLANATION AS TO THE SERVICE TO BE PROVIDED OR THE ITEM SOUGHT TO BE PURCHASED AND THE NECESSITY FOR IT:

____

____

____

____

PLEASE PROVIDE THREE QUOTES FOR THE SERVICE OR ITEM SOUGHT TO BE PURCHASED:

______________ **QUOTE:** $ ______________

______________ **QUOTE:** $ ______________

______________ **QUOTE:** $ ______________

PLEASE NOTE WHICH QUOTE TO BE ACCEPTED

180 Milan Avenue, Norwalk, Ohio 44857-1195
419-668-3092 • 800-808-5092 • Fax: (419) 663-3370
Email: main@hccommissioners.com
www hccommissioners com