Health Benefits Claim Form

For use with Humana Healthy Horizons in Ohio

INSTRUCTIONS

1. Complete ALL information requested below.
2. Use separate form for each family Member and/or for each accident illness.
3. Enclose ORIGINAL itemized bill, medical claim form, and receipt of payment. Keep a copy of this information for your records. We cannot accept CANCELLED checks as proof of bill.
4. Sign the Direct Payment block on this form, if you want us to pay your physician or healthcare provider.
   NOTE: We will pay benefits for hospital confinement directly to the hospital.
5. Send back this completed form to:
   Humana Member Experience, P.O. Box 14225, Lexington, KY 40512

Member Name (Last, First, Middle Initial)	Member ID	Group Number
Member Home Address	Group Name	
	Member Birth Date	Patient Birth Date
Patient Name (Last, First, Middle Initial)	Patient Relationship to Member	

Service Dates		Place of Service*	CPT Code/ Service Description	Diagnosis Code	Unit Charges	Days or Units	Total Charge
From	To						

Humana
Healthy Horizons®
in Ohio

Humana Healthy Horizons in Ohio is a Medicaid Product of Humana Health Plan of Ohio, Inc.

OHHLRTREN0623

Service Dates		Place of Service*	CPT Code/ Service Description	Diagnosis Code	Unit Charges	Days or Units	Total Charge
From	To						

*Place of Service Codes		CPT Code/Service Description	Physician, Supplier, and/or Group Name (Address, ZIP Code, Telephone Number, and Tax ID)
11	Doctor's Office		
12	Patient's Home		
20	Urgent Care Center		
21	Inpatient Hospital		
22	Outpatient Hospital		
23	Emergency Room		
24	Ambulatory Surgical Center		
31	Skilled Nursing Facility		
32	Nursing Home		
41/42	Ambulance (Land/Air)		
52	Inpatient Psychiatric Facility		

*Place of Service Codes		CPT Code/Service Description	Physician, Supplier, and/or Group Name (Address, ZIP Code, Telephone Number, and Tax ID)
55	Residential Substance Abuse Treatment Facility		
72	Rural Health Clinic		
81	Independent Laboratory		
99	Other Location(s)		

Release of Information: I authorize the release of any medical information necessary to process this claim. I understand that, as permitted by law, to the extent of benefits paid under this claim, the Plan acquires all rights of recovery I may have against other parties considered responsible for these expenses.

Direct Payment: To authorize us to pay your provider of services directly, please read the below statement and then sign and date in the space provided beneath the statement:

I hereby authorize payment directly to the provider of services, and I understand that I am financially responsible for the hospital, medical, or physician charges not covered by this payment authorization.

Patient or Authorized Person's Signature	**Date**

Any person who knowingly and with intent to defraud any insurance company and files a statement of claim containing any materially false information, or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime.

Patient or Authorized Person's Signature	**Date**
Member Signature	**Date**

Call If You Need Us

If you have questions or need help reading or understanding this document, call us at **877-856-5702 (TTY: 711)**. We are available Monday through Friday, from 7 a.m. to 8 p.m., Eastern time. We can help you at no cost to you. We can explain the document in English or in your preferred language. We can also help you if you need help seeing or hearing. Please refer to your Member Handbook regarding your rights.

Important

At Humana, it is important you are treated fairly.

Humana Inc. and its subsidiaries do not discriminate or exclude people because of their race, color, religion, gender, gender identity, sex, sexual orientation, age, disability, national origin, military status, veteran status, genetic information, ancestry, ethnicity, marital status, language, health status, or need for health services. Discrimination is against the law. Humana and its subsidiaries comply with applicable Federal Civil Rights laws. If you believe that you have been discriminated against by Humana or its subsidiaries, there are ways to get help.

- You may file a complaint, also known as a grievance:
  Discrimination Grievances, P.O. Box 14618, Lexington, KY 40512-4618.
  If you need help filing a grievance, call **877-856-5702** or if you use a **TTY**, call **711**.
- You can also file a civil rights complaint with the:
  - **Ohio Department of Medicaid (ODM), Office of Civil Rights** by emailing **ODM_EEO_EmployeeRelations@medicaid.ohio.gov**, faxing **614-644-1434**, or sending by mail to The Ohio Department of Medicaid, Office of Human Resources, Employee Relations, P.O. Box 182709, Columbus, Ohio 43218-2709; or
  - **U.S. Department of Health and Human Services**, **Office for Civil Rights** electronically through their Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or at **U.S. Department of Health and Human Services**, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, DC 20201, **800-368-1019, 800-537-7697 (TDD)**. Complaint forms are available at **https://www.hhs.gov/ocr/office/file/index.html**.

Auxiliary aids and services are available to you free of charge.

877-856-5702 (TTY: 711)

Humana provides free auxiliary aids and services, such as qualified sign language interpreters, video remote interpretation, and written information in other formats to people with disabilities when such auxiliary aids and services are necessary to ensure an equal opportunity to participate.

Humana Healthy Horizons in Ohio is a Medicaid Product of Humana Health Plan of Ohio, Inc.

Language assistance services, free of charge, are available to you.

877-856-5702 (TTY: 711)

English: Call the number above to receive free language assistance services.

Español (Spanish): Llame al número que se indica arriba para recibir servicios gratuitos de asistencia lingüística.

नेपाली (Nepali): नि:शुल्क भाषासम्बन्धी सहयोग सेवाहरू प्राप्त गर्नका लागि माथिको नम्बरमा फोन गर्नुहोस्।

العربية (Arabic): اتصل برقم الهاتف أعلاه للحصول على خدمات المساعدة اللغوية المجانية.

Soomaali (Somali): Wac lambarka kore si aad u hesho adeegyada caawimaada luuqada oo bilaash ah.

Русский (Russian): Позвоните по вышеуказанному номеру, чтобы получить бесплатную языковую поддержку.

Français (French): Appelez le numéro ci-dessus pour recevoir des services gratuits d'assistance linguistique.

Tiếng Việt (Vietnamese): Gọi số điện thoại ở trên để nhận các dịch vụ hỗ trợ ngôn ngữ miễn phí.

Kiswahili (Swahili): Piga simu kwa nambari iliyo hapo juu ili upate huduma za usaidizi wa lugha bila malipo.

Українська (Ukrainian): Зателефонуйте за вказаним вище номером для отримання безкоштовної мовної підтримки.

繁體中文 (Traditional Chinese)：您可以撥打上面的電話號碼以獲得免費的語言協助服務。

Ikinyarwanda (Kinyarwanda): Hamagara nomero iri haruguru uhabwe serivisi z'ubufasha bw'ururimi ku buntu.

简体中文 (Simplified Chinese): 您可以拨打上面的电话号码以获得免费的语言协助服务。

دری (Dari): برای دریافت خدمات رایگان کمک زبانی با شماره بالا تماس بگیرید.

پشتو (Pashto): د وړیا ژبې ملاتړ ترلاسه کولو لپاره پورته شمیرې ته زنګ ووهئ.

አማርኛ (Amharic): ነፃ የቋንቋ ድጋፍ አገልግሎቶችን ለማግኘት ከላይ ባለው ስልክ ቁጥር ይደውሉ።

ગુજરાતી (Gujarati): મફત ભાષા સહાય સેવાઓ મેળવવા માટે ઉપર આપેલા નંબર પર કૉલ કરો.