Health benefits claim form

For use with the Humana family of health insurance and health plan companies

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 bills and receipt of payment. Keep a copy of your bills and receipts 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 the address on the back of your Member ID card.

Member name (last, first, middle initial)	Member ID (9 characters)
Member home address	Group name (e.g., Medicaid, Humana Healthy Horizons, etc.)
	Member birth date

Service dates		Place of service*	CPT code/ service description	Diagnosis code	Unit charges	Days or units	Total charge
From	To						

Humana
Healthy Horizons®
in Louisiana

Humana Healthy Horizons in Louisiana is a Medicaid product of Humana Benefit Plan of Louisiana, Inc.

LAHLRTPEN0323

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.

Please note: 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.

Member or authorized person's signature	**Date**