Benefits Claim Form

Please mail completed form with itemized statement or receipts and an explanation of benefits form to:
HealthSmart Benefit Solutions ■ P.O. Box 99004 ■ Anchorage, AK 99509-9004
Toll Free 877.517.6370 ■ TDD 877.517.6416 ■ Fax 855.328.5176

For all services complete the following and attach an itemized statement. Information specific to dental or vision services are listed on the back side of this form. Prescription claims should be filed on either a Mail Order or Direct Member Reimbursement Form. Additional forms can be obtained on AlaskaCare.gov.

Select all that apply:
☐Medical ☐Dental ☐Vision ☐Audio

Medical/Audio (For medical/audio services complete the following and attach an itemized receipt).

Patient Information

Relationship To Member	Patient's Name (First, Initial, Last)	Date of Birth	Gender
○ Husband ○ Wife ○ Self ○ Son/Daughter ○ Other			○ M ○ F

	Name of School	Expected Date of Graduation
○ Full-Time Student ○ Half-Time Student		

If Injury Is Due To An Accident

Date of Accident	Place of Accident	Briefly Describe Accident
	○ At Work ○ At Home ○ Auto ○ Other	

Payment Information: Have these charges been paid in full? ○ Yes ○ No (If yes, please attach proof of payment)

Other Insurance/Medicare

Any other medical benefits for employee, spouse, or dependent?	If yes, who?
○ Yes ○ No	○ Self ○ Spouse ○ Dependent

If Dependent or Spouse, Full Name	Date of Birth	Dependent ID

Coverage Paid Through	Medicare Identification Number
○ Medicare ○ Medicaid ○ Other ○ Employer-Sponsored Plan ○ Private Policy ○ CHAMPUS	

Effective Date of Coverage	Last Day of Effective Coverage

Name of Other Insurance Company	Phone Number of Other Insurance Company

Please attach other insurance explanation of benefits, if applicable.

Employee/Retiree Information ○ Check here if this is a new address

Name (First, Initial, Last)	Member ID	Date of Birth	Gender
			○ M ○ F

Address	City	State	ZIP

Plan Name	Group Number
AlaskaCare	○ 5851 Actives ○ 5852 Retirees

Employment Status	Marital Status
○ Active ○ Retired ○ COBRA	○ Single ○ Married ○ Divorced ○ Legally Separated ○ Widowed

Payee Selection (required) ○ Issue payment directly to member. ○ Issue payment directly to provider of service.

I hereby certify the above information is true and correct. By signing this form I am authorizing the release of any health care records necessary to process this claim. I understand that payment will be issued to the payee that I have selected in the above section.

Employee's Signature	Date

For Dental Care (For dental services complete the following and attach an itemized statement.)

Select one of the following:

O Dentist's Pretreatment Estimate O Dentist's Statement of Actual Services

Dentist's Section

Dentist's Name

Address

City | State | ZIP

Dentist SS No./TIN | Dentist Lic. No. | NPI | Dentist Ph. No.

First Visit Date of Current Series

Place of Treatment: O Office O ECF O Hospital O Other

Radiographs/models enclosed? O Yes O No

How many?

Is treatment related to an illness or injury? No Yes

If yes, enter brief description and dates.

Place of Accident: O At Work O At Home O Auto O Other

Other Accident? No Yes

Are any services covered by another plan? No Yes

If prothesis, is this an initial placement? No Yes

(If no, reason for replacement)

Date of Prior Placement

Is treatment for orthodontics? No Yes

If Services Already Commenced Enter

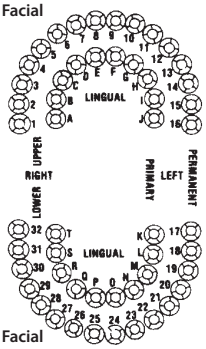
Date Appliances Placed

Months Treatment Remaining

Examination And Treatment Plan

Identify missing teeth with X.

Facial



Facial

Remarks for unusual services.

Examination and Treatment Plan ▪ List in order from tooth 1 through 32, A through T, using chart at left.

Tooth # or letter	Surface	Description of Service (including X-rays, prophylaxis, material used, etc.)	Date of Service (MM/DD/YY)	Procedure Number	Fee	For Administrative Use Only

I hereby certify that the procedures as indicated by date have been completed.

Signature (Dentist) | Date

Total Fee Charged

Patient Pays

For Vision Care (For vision services complete the following and attach an itemized statement.)

Physician Or Supplier Information

Did visual analysis indicate a change in prescription from the preceding prescription? O Yes O No

Charges

Exam (Date of Service) $

Lenses (Date of Service) $

Type of Lenses (Indicate all that apply)

O Single O Trifocal O Sunglasses and/or safety glasses

O Bifocal O Tinted O Other _____

Frames (Date of Service) $

Contacts (Date of Service) $

Please advise reason for contacts (Severe corneal astigmatism, severe corneal scarring, aphakia, patient prefers contacts, etc.)

Total Fee $

Indicate the greatest degree of visual acuity improvement achieved by contact lenses

Amount Due $

Indicate the greatest degree of visual acuity improvement achieved by glasses

Balance Due $

Individual Practitioner's Social Security Number (Must be furnished under authority of law)

Other Employer Tax ID Number (Must be furnished under authority of law)

Date | Physician's Name | Signature | ○ Ophthalmologist ○ Optometrist ○ Optician | Telephone

Street Address | City | State | ZIP