Eliance Health Solutions
Lancaster General Health

Please return completed form to:
Eliance Administrators, Attn: Customer Service
P.O. Box 7046, Lancaster, PA 17604-7046
Fax: 717-553-1125
Questions? Call 717-553-1124 or 1-855-408-8503

Medical Plan Claim Form

Instructions: Complete and sign form. If another plan has made its primary coverage, include a copy of the Explanation of Benefits (EOB). All provider charges must be itemized and include 1. Patient's Name 2. Date(s) of Service 3. Charge Amount(s) 4. Provider's Name/Address/Phone Number 5. Provider's Federal Tax Identification Number 6. Type of Service Rendered and 7. Diagnosis. Receipts, balance due notices and cancelled checks will not be accepted. We recommend that you make copies of your bill(s) and this completed form for your records.

Section A. SUBSCRIBER INFORMATION	
Subscriber (employee) Name:	Group#: Family ID #:
Subscriber's Employer:	Date of Birth: Daytime Phone#:
Section B. PATIENT INFORMATION – complete if Member is not the Subscriber	
Patient's Name:	Date of Birth: Last 4 Digits of Patient's Social Security Number:
Address (if different from Subscriber):	Relationship to Subscriber:
Section C. CLAIM INFORMATION	
State the condition for which the Patient was treated:	
Condition related to Patient's employment? ☐ No ☐ Yes If yes, explain:	Condition related to an accident? ☐ No ☐ Yes If yes, explain:
Section D. OTHER COVERAGE INFORMATION	
Is the Patient covered by any other group or individual health care plan, Medicare, Medicaid or any federal, state or local government plan? ☐ No ☐ Yes - If "yes, please include plan information, identification number and name/address of plan or carrier:	
Section E. RELEASE OF INFORMATION	
I certify that the above information is correct and that the bills attached were incurred by the Patient listed above. I understand that Eliance Administrators and my plan's use and disclosure of Protected Health Information (PHI) shall be in accordance with state and federal privacy regulations. Patient or Authorized Person's signature: Date:	
Section F. ASSIGNMENT OF BENEFITS	
I authorize payment of health care benefits to the physician/provider of services. Patient or Authorized Person's signature: Date:	

Caution: Any person who knowingly and with the intent to defraud any health plan or insurance company or other person: (1) files a claim for benefits containing materially false information; or (2) conceals for the purpose of misleading, information concerning any material fact thereto, commits a fraudulent act and may be subject to criminal and civil penalties.