align
powered by SANFORD HEALTH PLAN

Great Plains Medicare Advantage

1-877-509-4979 (TTY: 711)

1-877-492-5189 (TTY: 711)

PO Box 8000 Marshfield, WI 54449

Medical Claim Form

Member instructions: Complete and sign section one and give to your provider to complete section two.

Submission of this claim form does not guarantee payment of services. Claims may be delayed for missing information. Submit completed form, along with applicable receipts or itemized statements and proof of payment to the address above.

SECTION 1

Subscriber/Patient Insurance Information

SUBSCRIBER/PATIENT INFORMATION			
Subscriber's ID Number:		Date of Birth	
Subscriber's Name:		Telephone:	
Subscriber's Address:	City:	State:	Zip Code:
Are services for a work related injury? ☐ Yes ☐ No			
Patient's or Authorized Person's Signature: *I authorize the release of any medical or other information necessary to process this claim.* Signed: _____ Date Signed: _____			

Continued on back:

SECTION 2

Physician or Supplier Information

Date of Accident:	Referring Physician NPI:

Diagnosis Code:

_____ _____ _____ _____ _____

Date of Service: From: MM	DD	YY	To: MM	DD	YY	Place of Service	Procedures, services or supplies CPT/HCPCS	Modifier	Description of Services	Diagnosis Pointer	Charges	Days or Units	Rendering Provider NPI

Federal Tax ID Number ☐ SSN ☐ EIN	Patient Account Number:	Total Charges:

Service Facility Location Information:	Facility NPI:	Billing Provider Info and Phone Number:	Billing NPI:

Signature of physician or supplier including degrees or credentials:

Signed: _____ Date Signed: _____