



**Claims Mailing Address**  
 Lumenos  
 PO Box 11265  
 Alexandria, Virginia 22312

# Lumenos Customer Medical Claim Form

**Section A – Patient Information**

**Name:** \_\_\_\_\_  
 Last First M.I.

**Health Program ID:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_ **Gender:**  M  F  
 MM/DD/YYYY

**Address:** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Section B – Employee Information**

**Name:** \_\_\_\_\_  
 Last First M.I.

**Date of Birth:** \_\_\_\_\_  
 MM/DD/YYYY

**Address:** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Employer Name:** \_\_\_\_\_

**Patient Relationship to Employee:**

Self  Spouse  Child  Other

**Is Condition Related to:**

Employment  Auto Accident  Other Accident

"I authorize the release of any medical or other information necessary to process this claim."

\_\_\_\_\_  
 Signature of Patient or Authorized Representative Date

**Section C – Other Insurance Information:**

Other Insured's Name: \_\_\_\_\_

Other Policy Group or Plan Name: \_\_\_\_\_

Other Policy Group or Plan Number: \_\_\_\_\_

**Section D – Description of Service(s)**  
 You may attach an itemized receipt, however, the information below must be completed.

Date(s) of Service						Place of Service	Description of Service	Diagnosis	\$ Charges	Days or Units
From				To						
MM	DD	YY	MM	DD	YY					

Rendering Provider or Facility Name, Address and Phone Number:  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

( ) \_\_\_\_\_  
 Rendering Provider or Facility Tax Identification Number:  
 \_\_\_\_\_

Signature of Provider, including degree/credentials  
 If a receipt is enclosed which includes the date the service was rendered, the place of service, type of service, diagnosis code, charge and number of days or units, the provider's signature is not required.

**Section E – Payment Information:**  
 Do you wish payment to be made directly to your provider?  Yes  No

# Instructions for the Lumenos Customer Medical Claim Form

(This form excludes HRA Extras. If filing a claim for an HRA Extra, please complete an HRA Extra Claim Form)

When to use this form:

- Use this form when using a provider who is not offering a discount and when this provider is not submitting a claim on your behalf.
- Lumenos encourages you take this form to your provider and ask him/her to complete and sign the form for you.
- If you need to complete the form yourself, you will need to attach a receipt from your provider and follow the instructions below.

How to complete this form:

**Section A – Patient Information:** This section pertains to the person who is receiving services claimed on this form. This individual must be eligible for benefits under the Lumenos program, and may be the employee, spouse or a covered dependent.

- Name – The full name of the person receiving services for this claim.
- Health Program ID - The identification number found on the front of the Lumenos ID card.
- Date of Birth – The month, day and year of the patient's birth.
- Address – The patient's street address, city, state and zip code.
- Gender – Specify if the patient is male or female.
- Patient Relationship to Employee – Specify whether the person receiving services on this claim is the employee (self), or the employee's spouse, child or other dependent.
- Is Condition Related to Employment, Auto Accident or Other Accident – Indicate whether the services claimed on this form were a result of the patient's employment or an accident.
- Signature of Patient or Authorized Representative – This signature grants permission for Lumenos to obtain any information required to complete the payment of this claim. This may include specific medical information necessary to determine the appropriate benefit coverage. This signature also certifies the accuracy of the information provided on this form.

**Section B – Employee Information:** This section pertains to the employee through whose employer your Lumenos program is obtained. The employee may or may not be the actual patient indicated in Section A.

- Name – The full name of the employee through whom your Lumenos program is obtained. Please complete the name as it appears on your Lumenos ID card.
- Date of Birth – The month, day and year of the employee's birth.
- Address – The employee's street address, city, state and zip code.
- Employer Name – The name of the employer through whom your Lumenos program is obtained.

**Section C – Other Insurance Information:** This section should be completed if you have health insurance through any other plan in addition to your Lumenos program. For example, this could include coverage through another employer, Medicare, etc. **If you do not have any other health insurance plan outside your Lumenos program, you may skip Section C.**

- Other Insured's Name – This is the full name of the person who is the contract holder of the other insurance plan.
- Other Policy Group or Plan Name – This is the name of your other insurance plan. Please indicate the insurance company name as well as the group or plan name.
- Other Policy Group or Plan Number – This is the number assigned to the group by the insurance company administering the other plan. This number can typically be found on your ID card.

**Section D – Description of Services:** The section is used to specify exactly what services were received and how much was charged for each. Your provider may complete this section for you, or you can attach an itemized receipt, that includes all the information outlined below. Your receipt must specifically list each service and the charges for each.

- Date of Service – The month, day and year on which the service was received.
- Place of Service – Where the service was performed, i.e., office, outpatient laboratory.
- Description of Service – Specify what procedure was performed.
- Diagnosis – The specific diagnosis related to this claimed service.
- Charges – The amount that the provider is charging for the service.
- Number of Days or Units of Service – Indicate how many days or units of service were received for each specific procedure. For example, a typical office visit is one unit of service. If submitting a claim for four weekly office visits, the units would be four.
- Rendering Provider or Facility Name, Billing Address, Phone Number and Tax ID Number – The name of the provider rendering this service, and address where he/she wishes payment to be sent, phone number, as well as the applicable Tax ID number of the provider rendering service.
- Signature of Provider – *If you do not have a completed receipt, your provider must sign this claim form.* When the provider signs, he/she is certifying these services were performed by him/her and were medically indicated. **If attaching an itemized receipt, which includes the date the service was rendered, the place of service, type of service, diagnosis code, charge and number of days or units, the provider's signature is not required.**

**Section E – Payment Information:** This section is used to tell Lumenos if you want the check for your program benefits paid to you or your provider.

- Do you wish payment be made directly to your provider? – If you indicate yes, program benefits will be sent to your provider. You should indicate no if you have already paid your provider and wish program benefits be paid to you.

**ALL DATA REQUESTED ON THIS FORM MUST BE COMPLETED FOR CLAIMS CONSIDERATION. INCOMPLETE FORMS WILL BE SENT BACK TO YOUR ATTENTION FOR COMPLETION.**