Clover

Member Claim Submission Form

Member Information:

Name: (full name listed on Clover ID card) _____

Member ID: _____ **Date of Birth:** _____ /_____ /_____

Home Address: _____

City: _____ **State:** _____ **Zipcode:** _____

Phone Number: (_____) _____ - _____ **Gender:** ☐ Male ☐ Female

Hospitalization Information: (if applicable)

Admission Date: _____ /_____ /_____ **Discharge Date:** _____ /_____ /_____

Name of Facility: _____

Name of Admitting Physician: _____

Symptoms/Diagnosis: _____

Service Information:

Name of Doctor, Supplier or Health Care Professional Providing Service:

_____

Address: _____

1. **Service or Item received:** (e.g Annual physical, Office visit w/ x-rays, testing supplies, etc.)

   _____

   Date of Service: _____ /_____ /_____ **Amount Paid: $** _____

2. **If applicable, please provide a description for the illness or injury that prompted you to get treatment:**

   _____

   _____

   - If applicable, first date of illness or injury: _____ /_____ /_____
   - Condition was related to: (Check, if applicable)
     - ☐ Patient's Employment
     - ☐ Auto Accident
     - ☐ Other Accident: (Please describe) _____

Other Insurance:

Do you have other coverage? ☐ Yes ☐ No

Name of Other Health Insurance: (Check, if applicable)

_____

Address: _____

Subscriber ID #: (Other insurance) _____

Legal Disclaimer:
CONFIDENTIAL COMMUNICATION: This transmission is intended only for the individual or entity to which it is addressed and contains information that is confidential. If you have received this communication in error, please delete the email and contact the sender immediately. This information may have been disclosed to you from confidential records and may be protected by federal and state law. This information may include confidential mental health, substance abuse, alcohol abuse and/or HIV-related information. Federal and state law prohibits you from making any further disclosure of this information without the specific written consent of the person to whom it pertains, or as otherwise permitted by law. Any unauthorized further disclosure in violation of the law may result in a fine or jail sentence or both. A general authorization for the release of this information may not be sufficient authorization for further disclosure.

Please note that by completing this form, the sender is seeking monetary reimbursement from a federal healthcare program for healthcare services. The sender attests to the accuracy and truthfulness of the submitted information.

Signature: _____ **Date:** _____ /_____ /_____

Instructions on where/how to submit:

Please submit completed form along with an itemized bill from the doctor or supplier to:
Clover Health Attention: Claims
<P.O. Box 471
Jersey City, NJ 07303>
