Clover

Member Claim Submission Form

Where to submit

For durable medical equipment or services rendered that are not dental or vision related, submit to the following address:

Clover Health
Attention: Claims
P.O Box 471
Jersey City, NJ 07303

For reimbursements regarding dental or vision services, please follow the guidelines below.

For **dental services**, please submit the following:

1. Completed ADA Dental Claim Form provided online*
2. Copy of your Clover Member ID Card
3. Copy of any receipts for payments you made
4. Submit your claim to:
   DentaQuest
   P.O Box 2906
   Milwaukee, WI 53201

*If you are unable to complete the ADA Dental Claim Form, you can contact DentaQuest's customer service department at 1-800-466-7566 and they will be able to assist you. Their hours of operation are Monday – Friday from 8 am – 6 pm Eastern Time.

For **vision services**, please submit the following:

1. Copy of your Clover Member ID card
2. Copy of any receipts for payments you made
3. Submit your claim to:
   EyeQuest
   Attn: Vision Claims Processing
   P.O Box 433
   Milwaukee, WI 53201

To ensure that your claim is processed in a timely manner

Please use black or blue ink and print clearly and legibly or fill out this form online. Complete all required fields on the form. Ask your provider for provider and medical information, or you can bring this form with you and have your provider fill it out. Your submission may be denied if all required information is not provided. Be sure to submit a separate form for each claim. Please allow up to 60 days from received date for us to process your claim.

If you have other insurance or Medicare, please include the explanation of benefits (EOB).

How to get the maximum benefit

Use an in-network provider to receive the maximum benefit. You could be at risk by paying up front for a service or item that is not covered under your benefits. In-network providers are required to submit a claim to Clover and must abide by certain rules about how much they can bill for rendering covered services. When a provider submits a claim to Clover for payment, we are able to protect you from unexpected costs by comparing the amount billed with the amount Medicare approves. This ensures that payments made by Clover and by you are correct.

Please note that member cost share (deductibles, co-pays, and co-insurance) are non-reimbursable and submission of this form is not a guarantee of payment.

If you have any questions, please feel free to reach out to our Member Services Line at 1-888-778-1478. Our hours of operations are 8 am – 8 pm Eastern Time, 7 days a week. Please note, alternate technologies (e.g. voicemail) will be used on the weekends and holidays from April 1st through September 30th.

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Member Claim Submission Form

Member Information:				
Member Full Name:				Gender: ☐ Male ☐ Female
Member ID#: ☐ HMO ☐ PPO	Birth Date (MM/DD/YYYY): ______/______/________		Phone Number: (______) ______ - ________	
Address:				
City:		State:		ZIP Code:

Provider Information: (Ask your provider for this information or have them fill this out)			
Facility or Servicing Provider Name:			
Accepts Medicare Assignment? ☐ Yes ☐ No	Phone number:		
Address:			
City:		State:	ZIP Code:

Medical Information: (Ask your provider for this information or have them fill this out)	
Description of Service/Item Received:	
Description of Symptoms:	
Date(s) of Service:	Date of Illness/Injury:
Procedure Code(s):	Diagnosis Code(s):
Condition was related to: (if applicable) ☐ Patient's Employment ☐ Auto Accident ☐ Other Accident (Description):	
Amount Member Paid:	

Other Insurance: (If applicable)		
Name of Other Health Insurance:		Policy Number:
Address:		
City:	State:	ZIP Code:

Please Include the Following:

- Completed Member Claim Submission Form
- An Itemized Bill that includes:
  - Name and Address of Provider
  - Procedure Codes
  - Diagnosis Code
  - Date(s) of Services
  - Amount charged for each service

By signing below, I am stating the information provided above is, to the best of my knowledge, true and correct. I certify that, by completing this form, I am seeking monetary reimbursement from a federal healthcare program for healthcare services and authorize the release of any medical information necessary to process this claim.

Signature: ______________________________ **Date:** ________________

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.
Clover Health is a Preferred Provider Organization (PPO) plan and a Health Maintenance Organization (HMO) plan with a Medicare contract. Enrollment in Clover Health depends on contract renewal. This information is not a complete description of benefits. Call 1-888-657-1207 (TTY 711) for more information.