Member Claim Submission Form

Subscriber Information

Subscriber Name: __________________________ Subscriber ID: ________________________

Date of Birth: _______________________________ Gender: ______________________________

Is service related to **Illness, Injury, or Auto Accident?** (Circle applicable)

If applicable, first date of illness or injury: ____

If hospitalized:

Admission Date: ______________________ Discharge Date: ______________________

Name of Facility: ____

Name of Admitting Physician: ____

Symptoms/Diagnosis: ____

Name of Doctor or Health Care Professional Providing Service:

____

Address: ____

Service Received: ____

Do you have other coverage? Yes/No (Circle applicable)

Name of Other Health Insurance:

____

Address: ____

Subscriber ID #: ____

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:

Submit Claims to:

Clover Health
Attention: Claims
Harborside Financial Center
Plaza 10, Suite 803
Jersey City, NJ 07311