**Claim Form**

* Visityour provider for prescription drug, dental and international claim forms, or call the toll-free number on your ID card.

**Filing Requirements:**

* Complete a separate claim form for each covered family member.
* Enclose itemized receipts and make copies for your records. Procedure codes and diagnosis codes are required. Please obtain codes from your provider. See Section IV for required information.
* Do not file a claim if the provider is filing for the same services.
* Attach Explanation of Benefits if these services are covered by another insurance policy.
* Claims must be filed within 18 months from the date services were received, or they will be denied.
* Please see Section VI for mailing information.

|  |  |
| --- | --- |
| Section I – Claim Information | |
| ID | **«${doc['dc:title']}»** |
| Submitter | () |
| SCCF |  |
| Total Charge | $ |

|  |  |
| --- | --- |
| Section II – Mailing Information | |
| Name |  |
| Address |  |
| City, State, Zip | , |

|  |  |
| --- | --- |
| Section III – Remittance Information | |
| Mailing  Address | Medical Insurance Provider  P.O. Box 123  Anywhere, USA |