



Supplemental Medical Expense Plan Member's Report of Claim

INSTRUCTIONS

1. Complete and sign Part A.
2. Send the completed form together with any itemized bills you may have to:

Nationwide Health Plans
P.O. Box 15016
Sacramento, CA 95851-1016

PART A - TO BE COMPLETED BY MEMBER (PLEASE PRINT)

Certificate Number		
Member's Name		Date of Birth
Member's Address (Number and Street - City - State - Zip Code)		
If Claim is for a Dependent - Dependent's Name		Date of Birth
		Relationship
PLEASE COMPLETE IF CLAIM IS FOR AN ACCIDENT	How did the accident happen?	Where did it occur?
		Date and Time of Accident:
1. Is the Claimant employed?	<input type="checkbox"/> Yes <input type="checkbox"/> No	NAME AND ADDRESS OF CLAIMANT'S EMPLOYER: _____ Name _____ Street _____ City-State-Zip Code
2. Was this claim incurred during the course of employment?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
3. Is there any other insurance policy, plan, service plan, or Federal or State law covering this claim? (If "Yes", please complete the following information:)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Name of Other Plan and Address		
Other Policy No.	Certificate No.	Name of Insured on Other Plan
<p><i>For your protection, please note that under California Law it is unlawful to:</i></p> <ul style="list-style-type: none"> • Knowingly make or cause to be made any false or fraudulent claim for payment of a health care benefit. • Knowingly submit a claim for a health care benefit which was not used by, or on behalf of, the claimant. • Knowingly present multiple claims for payment of the same health care benefit with an intent to defraud. • Knowingly present for payment any undercharges for health care benefits on behalf of a specific claimant unless any known overcharges for health care benefits for that claimant are presented for reconciliation at that same time. • Every person who violates any of the above provisions may be punishable by imprisonment, or by fine not exceeding fifty thousand dollars (\$50,000), or by both. 		
CERTIFICATION		
By my signature below, I certify that to the best of my knowledge the above statements are true, correct and complete.		
Date	Signature of Member	Signature of Claimant, unless unable to sign (Signed by) (Relationship)