Coastal TPA, Inc.
Medical Claim Submission Form

This form is not necessary if your provider has submitted your claim for you.
For your convenience, in the future ask your provider to submit your claims directly to Coastal TPA, Inc.

<table>
<tr><td colspan="2">1. EMPLOYEE/RETIREE MEMBER IDENTIFICATION NUMBER</td><td colspan="3"></td></tr>
<tr><td colspan="2">2. PATIENT NAME</td><td>3. PATIENT BIRTHDATE SEX
MM DD YY
M F</td><td colspan="2">4. EMPLOYEE/RETIREE NAME (Last, First, Middle Initial)</td></tr>
<tr><td colspan="2">5. PATIENT ADDRESS (Number, Street)</td><td>6. PATIENT RELATIONSHIP TO PERSON IN 4
Self Spouse Child Other</td><td colspan="2">7. EMPLOYEE/RETIREE ADDRESS (Number, Street)</td></tr>
<tr><td>CITY</td><td>STATE</td><td>8. PATIENT STATUS
Single Married Other</td><td>CITY</td><td>STATE</td></tr>
<tr><td>ZIP CODE</td><td>TELEPHONE (Include Area Code)</td><td>Full Time Student
Employed Part Time Student</td><td>ZIP CODE</td><td>TELEPHONE (Include Area Code)</td></tr>
<tr><td colspan="2">9. IS PATIENT COVERED UNDER ANOTHER GROUP MEDICAL/VISION PLAN?
YES NO If yes, please complete item 9a – 9c.</td><td>10. IS PATIENT'S CONDITION RELATED TO
a. EMPLOYMENT (CURRENT OR PREVIOUS)
YES NO</td><td colspan="2">11. EMPLOYEE/RETIREE GROUP NUMBER</td></tr>
<tr><td colspan="2">9a. NAME OF POLICYHOLDER IN ITEM 9</td><td>b. AUTO ACCIDENT?
PLACE (STATE)
YES NO ____________</td><td colspan="2">12. EMPLOYER NAME</td></tr>
<tr><td colspan="2">9b. IDENTIFICATION NUMBER OF POLICYHOLDER IN ITEM 9

9c. NAME OF GROUP MEDICAL PLAN FOR POLICYHOLDER IN ITEM 9</td><td>c. OTHER ACCIDENT?
YES NO</td><td colspan="2">13. EMPLOYEE/RETIREE OR AUTHORIZED PERSON'S SIGNATURE
I authorize payment of medical benefits to the physician or provider for services described in the attached itemized bill.
SIGNED: ______________________________</td></tr>
<tr><td colspan="5">14. PATIENT OR AUTHORIZED PERSON'S SIGNATURE
I authorize the release of any medical or other information necessary to process the attached itemized bill. I hereby certify the information provided is correct and true to the best of my knowledge.
SIGNED: ____ DATE: ______________________________</td></tr>
</table>

- **<u>If you wish payment to be made directly to you</u>**, leave item 13 above ***unsigned***.
- **<u>When submitting your own claims</u>** complete this form and attach an itemized bill from the provider that includes patient name, provider name/ address/ taxpayer identification number, date(s) of service, diagnosis code(s), (primary/secondary) describing the condition, procedures codes(s), place of service and itemized charges.
- **<u>If the patient has other coverage</u>**, please attach a copy of the other claims administrator's explanation of benefits, if available. This information may be required to process your claim.

PLEASE SUBMIT CLAIMS TO:	Coastal TPA, Inc. P.O. Box 80308 Salinas, CA 93912-0308

INSTRUCTIONS FOR COMPLETING MEDICAL CLAIM SUBMISSION FORM

The following is an item-by-item description of the questions appearing on the reverse side of this form. All questions should be answered as completely as possible to facilitate prompt benefit administration and to reduce follow-up questions. **Note**: The term "employee/retiree" used on this form refers to the plan participant (e.g., employee, retiree, union member, associate, surviving spouse, or those eligible under continuation of coverage).

ITEM NO.	INSTRUCTIONS
1.	**Employee/retiree member identification number**: Enter the employee/retiree's identification number.
2.	**Patient name:** Enter the patient's name (last name, first name, middle initial).
3.	**Patient birth date and sex:** Enter the patient's birthdate (month, day, year) and gender.
4.	**Employee/retiree name:** Enter the employee/retiree's name (last name, first name, middle initial).
5.	**Patient address:** Enter the patient's address (house number and street, city, state, zip code) and telephone number with area code.
6.	**Patient relationship to person in 4:** Indicate the patient's relationship to the person listed in item 4. If the employee/retiree is the patient, check "Self". If the patient is a spouse or child, check "Spouse" or "Child". If the patient is neither self, spouse, or child, check "Other".
7.	**Employee/retiree address:** Enter the employee/retiree's address (house number, street, city, state, zip code) and telephone number with area code.
8.	**Patient status:** indicate the patient's status (Single, Married, or Other, and Employed, Full-Time Student, or Part-Time student), as appropriate.
9.	**If there is other coverage, name and policyholder:** If the patient has other health coverage, check yes, and go to the box underneath, 9a., following the instructions as listed below.
9a.	**Name of the policyholder in item 9:** Enter the name of the person carrying the other coverage.
9b.	**Identification number of policyholder in item 9:** Enter the identification number of the person carrying the other coverage.
9c.	**Name of Group Medical Plan for policyholder in item 9:** Enter the name of the other plan or program for the policyholder carrying the other coverage, whose name appears in box 9a.
10.	**Is patient's condition related to:** Check each of the boxes marked "Yes" or "No" as appropriate under a., b., and c., and if an auto accident write the two-letter abbreviation for the state where the accident occurred (i.e., CA).
11.	**Employee/retiree group number:** This has already been supplied; do not write in this box.
12.	**Employer name:** This has already been supplied; do not write in this box.
13.	**Employee/retiree or authorized person's signature:** This is the "assignment of benefits." Sign here **ONLY** if you want benefits paid directly to the provider of services.
14.	**Patient or authorized person's signature:** Signature of patient or their authorized representative for the release of information.

This form should be used for medical expenses including, but not limited to, doctor services, laboratory, therapies, durable medical equipment/ supplies, and psychiatric treatment. All services are subject to plan provisions, limitations, and exclusions.