



MEDICAL CLAIM FORM
Claims Receipt Center
P.O. Box 211184
Eagan, MN 55121

TO BE COMPLETED BY PATIENT

PHYSICIAN OR SUPPLIER INFORMATION

1. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY – RELATE DIAGNOSIS TO PROCEDURE IN COLUMN D
BY REFERENCE NUMBER 1, 2, 3, ETC. OR DX CODE

Language Assistance Services

ATENCIÓN AL CLIENTE

Tagalog: PAUNAWA: Kung nagsasalita ka ng
Tagalog, magagamit mo ang mga serbisyo na tulon

Discrimination is Against the Law

This Plan complies with applicable Federal civil rights

regulations. If you believe that This Plan has failed