

Out-of-Network Claims

If you are using out-of-network benefits and requesting direct reimbursement to the subscriber, please submit your claims using the CMS(HCFA)-1500 to MHN. You may access an electronic version of the form by clicking [CMS\(HCFA\)-1500](#). Please fill the form out using the following guidelines:

PLEASE TYPE OR PRINT CLEARLY; THIS FORM WILL BE ELECTRONICALLY SCANNED.

BOX #:

- 1 Check **Group Health Plan**
- 1a Enter **Subscriber #** (Social Security Number).
- 2 Enter **Patient** Name
- 3 Enter **Patient** date of birth
- 4 Enter **Subscriber** Name
- 5 Enter **Patient** address
- 6 Indicate **Patient relationship to Subscriber**
- 7 **Subscriber** address
- 8 Indicate marital/employment status for **Patient**
- 9 Boxes a - d are **required if the patient is covered by more than one health plan/insurance policy**. For Box 9, Enter the full name of the Subscriber for this additional health plan.
- 9a Enter **that Subscriber's** policy or group number.
- 9b Enter **that Subscriber's** Date of Birth and Gender.
- 9c The Employer (or School, if applicable) information for **that Subscriber**
- 9d The plan or program name **for that Subscriber's health plan**
- 10 Boxes a - c should be filled out with information pertaining to the **Patient**
- 11 Enter information pertaining to **Patient**
- 11a Enter Date of Birth for **Subscriber**
- 11b Enter Name of **Subscriber's Employer Group**
- 11c **This field not required**
- 11d If answer is **Yes**, 9 a-d must also be filled out.
- 12 **Patient's Signature**. In cases where patient is a minor child, should be signed by parent or legal guardian.
- 13 **A signature in this box indicates that reimbursement is to be sent to the treating professional. If the subscriber is to be reimbursed, do not sign. (note that if you do not sign here, reimbursement will be sent to the subscriber, whether or not the subscriber is also the patient.**

Boxes 14 through 33 should be completed by the treating practitioner when service is rendered.

Mail your completed CMS (HCFA)-1500 to:
MHN / HMC Claims
P.O. Box 14621
Lexington, KY 40512- 4621

DEFINITIONS:

Subscriber: The person who is insured; the employee

Patient: The person who is accessing the service. The patient may be the subscriber, or may be a dependent of the subscriber.