CLAIM FORM

Please forward to: Volusia Health Network, P.O. Box 2814, Daytona Beach, FL 32120
Phone: 386−425−4846, option 1.

LIST ALL COVERED DEPENDENTS ON THIS FORM − AN UPDATED CLAIM FORM IS REQUIRED ANNUALLY.

Section 1 − SUBSCRIBER INFORMATION

Subscriber's Name	❑ Active ❑ Retiree ❑ Cobra	**Volusia Health Network ID #** ___ ___ ___ − ___ ___ ___ − ___ ___ ___ ___	**Date of Birth**

Mailing Address	**City**	**State**	**Zip Code**

Subscriber's Email Address (not halifax.org)

Are you currently working for another employer? ❑ No ❑ Yes − **If yes, name of other employer:**

If Retiree: Are you currently working at Halifax Health? ❑ No ❑ Yes

Employer: ❑ **Halifax Health** ❑ **Other:**

Is Subscriber covered by any other insurance (other than Volusia Health Network)? Please attach a copy of insurance card.
❑ **No − Go to Section 2** ❑ **Yes − Other Health Insurance − complete Section A below**

Section A: Name of Other Health Insurance Carrier	**Effective Date**

Name of Policy Holder (person who has the policy)	**Policy Holder's Social Security #**	**Policy Holder Date of Birth**

Section 2 − DEPENDENT INFORMATION (if covered on subscriber's policy)

Relationship	**First Name**	**Last Name**	**Birth Date**	**Covered by other insurance?**	**Effective Date − Other Coverage**
Spouse: Is spouse disabled? ❑ No ❑ Yes				❑ No ❑ Yes If yes, name of carrier: _____ (attach copy of card)	
Child: Is child subject to divorce decree? ❑ No ❑ Yes If yes, copy required.				❑ No ❑ Yes If yes, name of carrier: _____ (attach copy of card)	
Child's current address:					
Child: Is child subject to divorce decree? ❑ No ❑ Yes If yes, copy required.				❑ No ❑ Yes If yes, name of carrier: _____ (attach copy of card)	
Child's current address:					
Child: Is child subject to divorce decree? ❑ No ❑ Yes If yes, copy required.				❑ No ❑ Yes If yes, name of carrier: _____ (attach copy of card)	
Child's current address:					

"Any person who knowingly and with intent to injure, defraud, or deceive any insurance company files a statement of claim containing any false, incomplete or misleading information is guilty of a felony of the third degree." Florida Statutes, Section 817. 234

Subscriber Certification: I certify that all information provided on this form and on the attached itemized statements are true and correct to the best of my knowledge. I authorize any doctor, hospital, other provider of care or supplies, employer, labor union, or insurance company to furnish Volusia Health Network or its representatives any information required to process this claim. A photocopy of this should be honored.

Subscriber Signature X	**Date**

******* Please complete and return this form as soon as possible. Failure to do so could delay payment of your claims. ****** N−HMC − 494 − 10/15