MCA Administrators Medical Claim Form

IMPORTANT: Read the following instructions carefully as incorrect, incomplete or illegible claims may result in claim payment being delayed or denied.

1. Enter all requested information in the Patient Information and Subscriber Information sections. Claims may be delayed if information is missing.
2. Enter name, Address and Telephone Number of the provider of services in the Provider Information Section.
3. **Attach the original itemized receipts which include a breakdown of services.**
4. Sign and date the form.

Mail the completed claim form to: MCA Administrators, Inc.
Manor Oak Two, Suite 605
1910 Cochran Road
Pittsburgh, PA 15220

If you are an employee or a dependent of an employee and you have any question, please call 1-800-922-4966.

PATIENT INFORMATION *(Required)*

LAST NAME		FIRST NAME		MI	ID NUMBER OR SSN	
STREET ADDRESS		CITY	STATE	POSTAL CODE		TELEPHONE # ( )
BIRTH DATE	SEX ☐ M ☐F	RELATIONSHIP TO EMPLOYEE ☐Self ☐Spouse ☐Child ☐Other		PATIENT STATUS ☐Employed ☐Full-Time Student		

EMPLOYEE INFORMATION *(Required)* ☐ **Same as Patient**

LAST NAME		FIRST NAME		MI	ID NUMBER OR SSN	
STREET ADDRESS		CITY	STATE	POSTAL CODE		TELEPHONE # ( )
BIRTH DATE	SEX ☐ M ☐F	EMPLOYER NAME				
INSURANCE INFORMATION						

PROVIDER INFORMATION *(Required)*

PROVIDER NAME		TELEPHONE # ( )	
STREET ADDRESS	CITY	STATE	POSTAL CODE

REQUEST FOR REIMBURSEMENT – Paid Receipt must be attached: **$**

FRAUD WARNING: Any person who knowingly files a statement of claim containing any misrepresentations or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

Patient's or Authorized Person's Signature: I authorize the release of any medical or other information necessary to process this claim. By signing below, I acknowledge that I have read the Fraud Warning.

Patient's Signature ______________________________ Date ____________________