ALLIED PILOTS ASSOCIATION
VOLUNTARY SUPPLEMENTAL MEDICAL AND CUSTODIAL CARE BENEFIT PLAN CLAIM FORM
TERTIARY COVERAGE - MEDICARE ELIGIBLE

Return completed form to:
Luminare Health
P.O. Box 4187 Clinton, IA
52733-4187
1-877-498-8937

ALL CLAIMS MUST BE FILED WITHIN 1 YEAR OF DATE OF SERVICE.

SECTION A **Complete this section for all claims.**	Name *(Last, First, Middle Initial)*		Employee Number	
	Mailing Address (☐ *Check if new address)*	City	State	Zip Code
	Date of Birth (Month/Day/Year)	Day Telephone Number		
SECTION B **Complete this section for all claims.**	CERTIFICATION AND AUTHORIZATION *I certify that all the above statements are correct and complete and that the attached bill{s) represent actual services, dates and fees charged to me or my eligible dependents. I authorize the plan and its agents to take any appropriate action to receive expenses paid as the result of the acts or omissions of another person. To all physicians, hospitals, medical service providers, pharmacists, employers and other agencies or organizations: I agree that Luminare Health and their authorized representatives may see or obtain a copy of all medical, mental and dental care, drug or alcohol treatment prescribed drug, employment and insurance coverage records necessary for the proper administration of the plan which pertains to patient. Such information may be used to the extent deemed necessary by Luminare Health to determine the value or amount payable on account of this claim.* Member Signature _____ Date _____ *NOTE:* A *photocopy of the above authorization is as valid as the original.*			

01/25

Enclosure: UHC Explanation of Benefits

DIRECTIONS:

Step 1 - Complete and sign this claim form.
Step 2 - Copy and attach your UHC Explanation of Benefits.
Step 3 - Mail claim form and attachment to address listed above.
Step 4 - Plan participant must file the Luminare Health Tertiary claim form, attach a copy of the UHC Explanation of Benefits, and an itemized statement from the provider, if the amount of Eligible Expenses remaining after payment has been made by Medicare and UHC is over $1000.
Step 5 - Plan participant must submit the UHC EOB and complete the Tertiary claim form, if the amount of Eligible Expenses remaining after payment has been made Medicare and OGHC is under $1000.