



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

TO BE COMPLETED BY PATIENT

[The form area contains numerous horizontal lines and blacked-out sections, indicating redacted or obscured information.]

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

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

ATENCIÓN: Si habla español, puede utilizar los servicios de asistencia lingüística.

This Plan complies with applicable Federal civil rights

regulations. If you believe that This Plan has failed