



**MEDICAL CLAIM FORM**

Claims Receipt Center

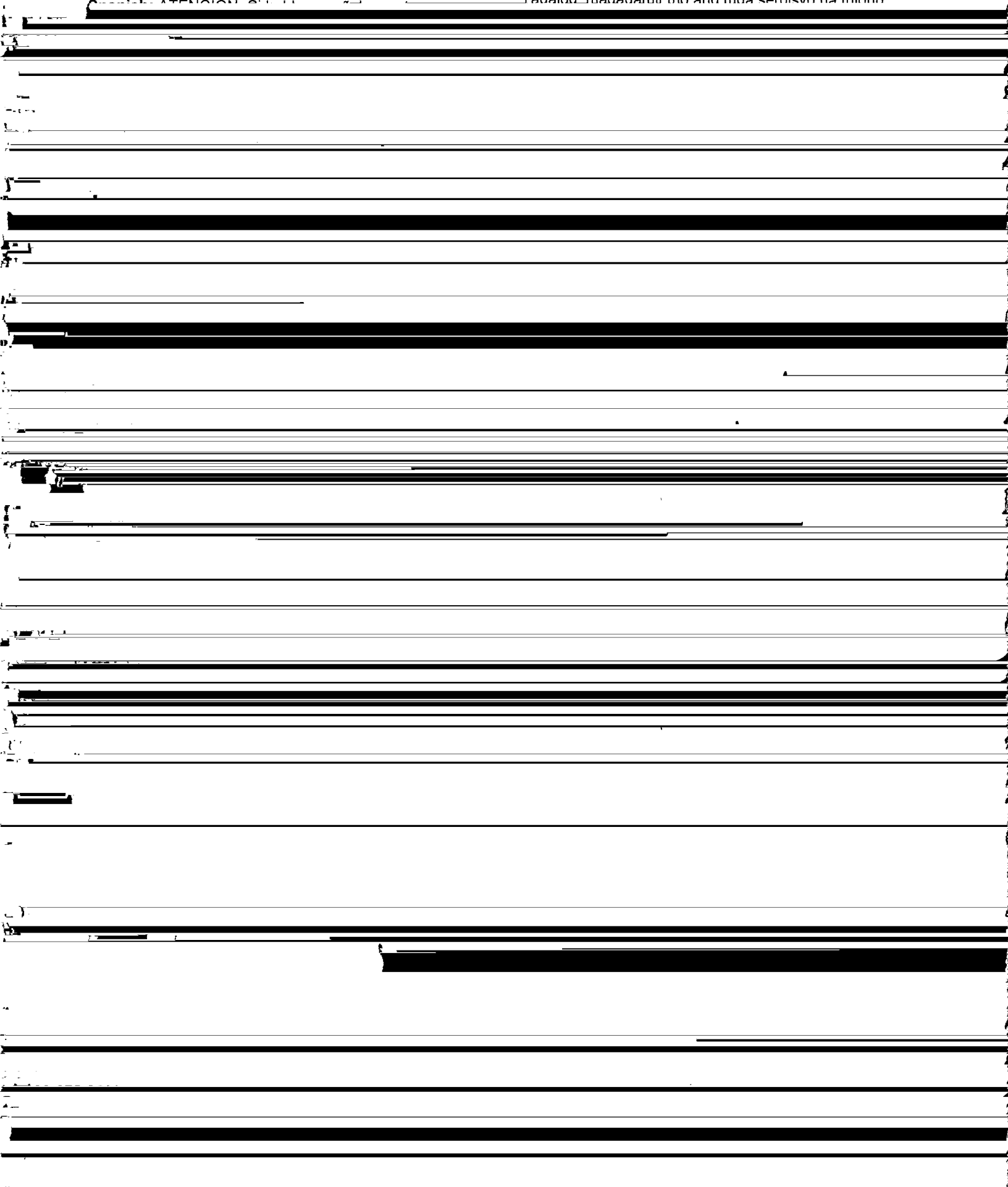
P.O. Box 211184

Eagan, MN 55121

**TO BE COMPLETED BY PATIENT**

**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



This Plan complies with applicable Federal civil rights

regulations. If you believe that This Plan has failed