American Specialty Health Networks

To expedite the processing of your claim, please complete this claim form and attach the signed "Super Bill" or signed "Invoice" from the Provider of Services. Without the attached bill or invoice we will be unable to process your claim, which would result in non-payment.

| **Subscriber Information** | |
|---|---|
| Subscriber Name (Last, First, MI) | Subscriber ID |
| | |

| **Patient's Information** | | |
|---|---|---|
| Patient's Name (Last, First, MI) | | Patient's Member ID |
| | | |
| Patient's Date of Birth | Patient's Sex | Relationship to Subscriber |
| | Male ☐ Female ☐ | Self ☐ Spouse ☐ Dependent ☐ |
| Other Insurance Name | Other Insurance ID Number | Is Patient's condition related to: |
| | | Auto ☐ Other ☐ Employment ☐ |
| Patient's Address | | |
| Street | | |
| City | State | Zip |

| **I certify that the information above is correct. I also understand that it is a crime to knowingly make any false statement to obtain compensation.** | |
|---|---|
| Signature | Date |

| **Insured's or Authorized Person's Signature** I authorize payment of medical benefits to the physician or supplier of services listed below: | |
|---|---|
| Provider Name | Tax ID |
| Signature | Date |

Please mail your completed claim form to:

ASH NETWORKS
PO BOX 509001
SAN DIEGO, CA 92150-9001

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