Independence

MEDICAL CLAIM FORM

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

[redacted]

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

**Language Assistance Services**

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

[redacted]

Discrimination is Against the Law

[redacted]

This Plan complies with applicable Federal civil rights [redacted] Coordinator. If you believe that This Plan has failed [redacted]