State of Maryland

Employee/Retiree/Dependent Claims Submission Form
MEMBER PAY**

Please complete all information below to avoid a delay in processing.

Date: _____

Patient Name: _____

Patient's Date of Birth: _____

Subscriber's APS ID#: _____

Subscriber's SSN#: _____

Please attach an itemized, legible provider bill that includes:

- **The charges for services rendered**
- **The date(s) of service**
- **Provider name, credentials, tax identification #, and address**
- **ICD-9 Diagnosis and type of treatment provided (CPT code)**
- **Patient's name and date of birth**

**If you or your provider submit a CMS 1500 form with this cover sheet for reimbursement to the member, please DO NOT SIGN Box 13 (assignment of benefits).

**If you would like to have your provider reimbursed directly by APS, please ask your provider to submit a CMS 1500 for (no cover sheet required) directly to APS. You should then sign Box 13 of the CMS 1500 form to assign payment to your provider.

Send claims to:
APS/SOM Claims Unit
P.O. Box 99
Linthicum, MD 21090

For any further questions regarding submission of claims, please call the APS dedicate State of Maryland Team at: 1-877-239-1458.