

5% Max Claim Form

My 5% max is: _____

Family Assistance C.A.R.E. Coordinator: (Tel.) 1-800-462-1120.

Parent/Guardian Name: _____ Parent/Guardian SSN: _____

Health Insurance Company: _____

Use this form to (1) keep track of your children's medical services to show you have reached the 5% max; and (2) bill MassHealth for copays, deductibles, and coinsurance once you have reached your 5% max. Complete one line for each copay, deductible, or coinsurance bill or receipt. Attach extra claim form pages if you run out of space. See the booklet in your C.A.R.E. Kit for more information.

Name of Child	Child's SSN	Date of Visit	Did you pay this bill? <input type="checkbox"/> Yes <input type="checkbox"/> No	Amount of copay, coinsurance, or deductible
Name and mailing address of health-care provider				
Name of Child	Child's SSN	Date of Visit	Did you pay this bill? <input type="checkbox"/> Yes <input type="checkbox"/> No	\$ _____
Name and mailing address of health-care provider				
Name of Child	Child's SSN	Date of Visit	Did you pay this bill? <input type="checkbox"/> Yes <input type="checkbox"/> No	\$ _____
Name and mailing address of health-care provider				
Name of Child	Child's SSN	Date of Visit	Did you pay this bill? <input type="checkbox"/> Yes <input type="checkbox"/> No	\$ _____
Name and mailing address of health-care provider				
Name of Child	Child's SSN	Date of Visit	Did you pay this bill? <input type="checkbox"/> Yes <input type="checkbox"/> No	\$ _____
Name and mailing address of health-care provider				
Name of Child	Child's SSN	Date of Visit	Did you pay this bill? <input type="checkbox"/> Yes <input type="checkbox"/> No	\$ _____
Name and mailing address of health-care provider				
Name of Child	Child's SSN	Date of Visit	Did you pay this bill? <input type="checkbox"/> Yes <input type="checkbox"/> No	\$ _____
Name and mailing address of health-care provider				
Name of Child	Child's SSN	Date of Visit	Did you pay this bill? <input type="checkbox"/> Yes <input type="checkbox"/> No	\$ _____
Name and mailing address of health-care provider				

Grand Total: **Page 1 of** _____ **Total Amount This Page:**

Send the claim form(s) and a copy of each receipt or bill to:
MassHealth, BC & R, Family Assistance C.A.R.E. Coordinator, P.O. Box 120068, Boston, MA 02112.

Commonwealth of Massachusetts ■ Executive Office of Health and Human Services ■ Office of Medicaid

