HEALTH CARE CLAIM SUBMISSIONS RECORD
For Medicare Enrollees

For additional copies, call STRS Ohio toll-free at 888-227-7877.

STRS OHIO HealthCare PROGRAM

PATIENT'S NAME: _____

Date of Service	Doctor or Provider	Type of Service	Total Charges	Patient's Initial Payment to Provider		Medicare Advantage Plans Aetna Medicare Plan AultCare PrimeTime Health Plan Paramount Elite Annual Deductible Hospital $ _____ Medical $ _____			Medical Mutual Basic Annual Deductible $ _____			Other Insurance Annual Deductible $ _____			Balance Remaining to Be Paid by Patient		Comments
				Amount Paid	Date Paid	Date Mailed	Amount Paid*	Date Paid	Date Mailed	Amount Paid*	Date Paid	Date Mailed	Amount Paid*	Date Paid	Amount Paid	Date Paid	

*Place an asterisk (*) next to costs in this column that apply to the annual deductible.

HEALTH CARE CLAIM SUBMISSIONS RECORD
For Non-Medicare Enrollees

For additional copies, call STRS Ohio toll-free at 888-227-7877.

STRS OHIO HealthCare PROGRAM

PATIENT'S NAME: _____

Date of Service	Doctor or Provider	Type of Service	Total Charges	Patient's Initial Payment to Provider		Medical Mutual Basic Aetna Basic AultCare Paramount Health Care Annual Deductible $ _____			Other Insurance Annual Deductible $ _____			Balance Remaining to Be Paid by Patient		Comments
				Amount Paid	Date Paid	Date Mailed	Amount Paid*	Date Paid	Date Mailed	Amount Paid*	Date Paid	Amount Paid	Date Paid	

12-140, 10/20/0

*Place an asterisk (*) next to costs in this column that apply to the annual deductible.