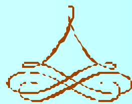
SAMPLE

"GALAXY Preferred Provider Organization"

ID CARD

(front)



Sponsor/Organization Name

Name: First & Last Name	Office Visit: $15
SSN: 000-00-0000	Emergency Room: $50
Eff Date: MM-DD-YY	Urgent Care Facility: $15

Group#:
Group Name:
Sponsor Name
Coverage: Medical EMP/SP/CH
Rx Prescriptions Brand Copay: $5 Generic Copay: $5
Pharmacist's Help Desk: 800-XXX-XXXX

(back)

Galaxy Health Network is your PPO.
Your Provider should mail claims to the following address.

In-Network Claims should be mailed to:
Galaxy Health Network
P.O. Box 201425
Arlington, Texas 76006-1425

Out of Network Claims should be mailed to:
Company Name
Department
Mailing Address

SAMPLE GALAXY PREFERRED PROVIDER ORGANIZATION ID CARD

Fronts

(Provider)

Organization Name

Group #__________ Plan #________

ID# _________________________

EMPLOYEE **SPOUSE** **DEPENDANT**

(Pharmacy)

Health Plan Name
Medical / Dental and Prescription Coverage
To verify coverage and for hospital / surgical pre-certification call:
(800) XXX-XXXX

Submit claims directly to:
P.O. Box XXXX, City, State, Zip

Covered persons may authorize payment directly to hospital or physician.

PHARMACY DIRECTIONS:

*This is a 100% CO-PAYMENT PLAN
*Price ON-LINE through XXXXXX
*Program Group/Plan Number: XXX-XXXXX

For pharmacy locations call: (800) XXX-XXXX 8:00am –5:00pm CST

Backs

(Provider)

Submit Claims To:
Claim Processing Center Name
P. O. Box XXXXXX
City, State Zip
For PPO Hospital information Call: (800) XXX-XXXX
To confirm and verity benefits Call: (800) XXX-XXXX
Pre-Certification is required for all hospital admission and outpatient surgical procedures. Call: (800) XXX-XXXX
Rx Claims: (800) XXX-XXXX

Galaxy Health Network
National Provider Network

(Pharmacy)

PARTICIPATING PROVIDERS

Albertson's, CostCo, Drug Emporium, Eckerd, HEB, K-Mart, Price Costco, Publix, Rite-Aid, Safeway, Target, Tom Thumb, Winn Dixie
Call (800) XXX-XXXX for additional participating providers and their locations

How To Use This Discount Prescription Program

Go to a participating pharmacy, present this identification card for your discounted price, pay for the prescription

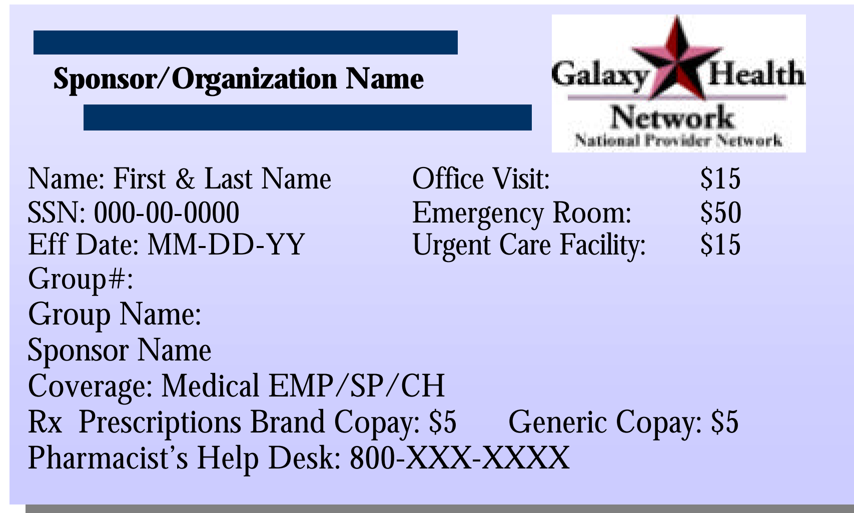
Galaxy Health Network
National Provider Network

SAMPLE

"GALAXY PREFERRED PROVIDER ORGANIZATION"

ID CARD

(front)



Sponsor/Organization Name

Galaxy Health Network
National Provider Network

Name: First & Last Name	Office Visit:	$15
SSN: 000-00-0000	Emergency Room:	$50
Eff Date: MM-DD-YY	Urgent Care Facility:	$15

Group#:
Group Name:
Sponsor Name
Coverage: Medical EMP/SP/CH
Rx Prescriptions Brand Copay: $5 Generic Copay: $5
Pharmacist's Help Desk: 800-XXX-XXXX

(back)

This card is for identification purposes only.
Hospital admissions must be pre-certified 48 hours to admission. Notice of emergency admission must be made within 48 hours. Failure to comply will reduce benefits.
Important Telephone Numbers:

24 Hour Automated Claim Info. Line	XXX-XXX-XXXX	800-XXX-XXXX
Claim Customer Service	XXX-XXX-XXXX	800-XXX-XXXX
Claim Fax Line	XXX-XXX-XXXX	
Pre-Certifications	XXX-XXX-XXXX	800-XXX-XXXX

Mail All Galaxy PPO Claims To:
GALAXY HEALTH NETWORK
P.O. BOX 201425, ARLINGTON, TX 76006-1425
MAIL ALL OTHER CLAIMS TO:
COMPANY NAME
P.O. BOX 000000, CITY, STATE ZIP CODE

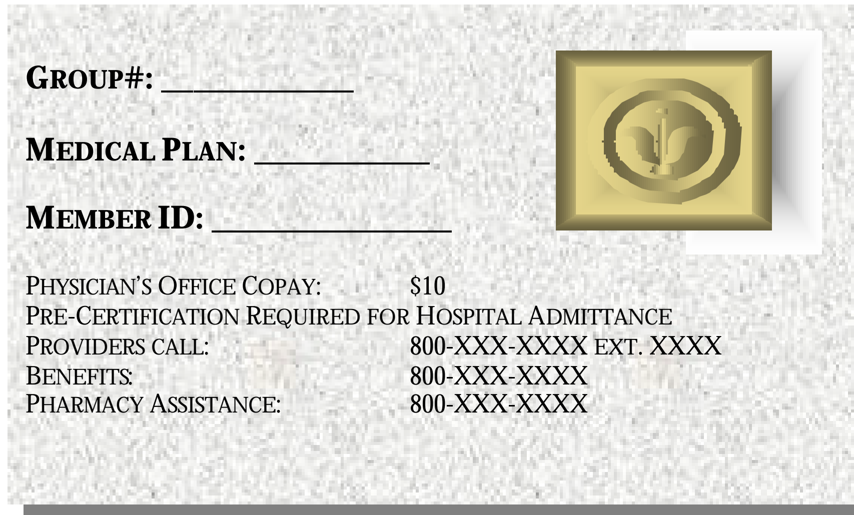
TO IDENTIFY A PPO PROVIDER, CALL 800-975-3322 OR WEBSITE www.galaxyhealth.net

SAMPLE

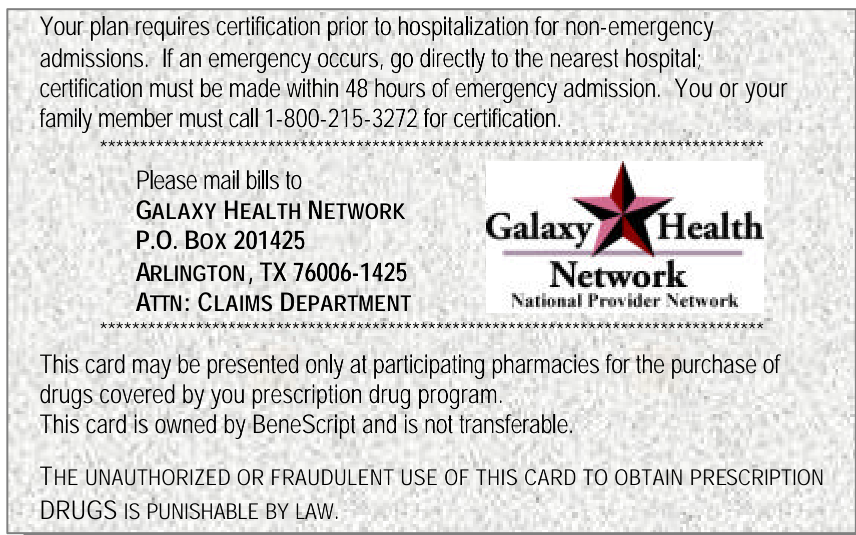
"GALAXY PREFERRED PROVIDER ORGANIZATION"

ID CARD

(front)

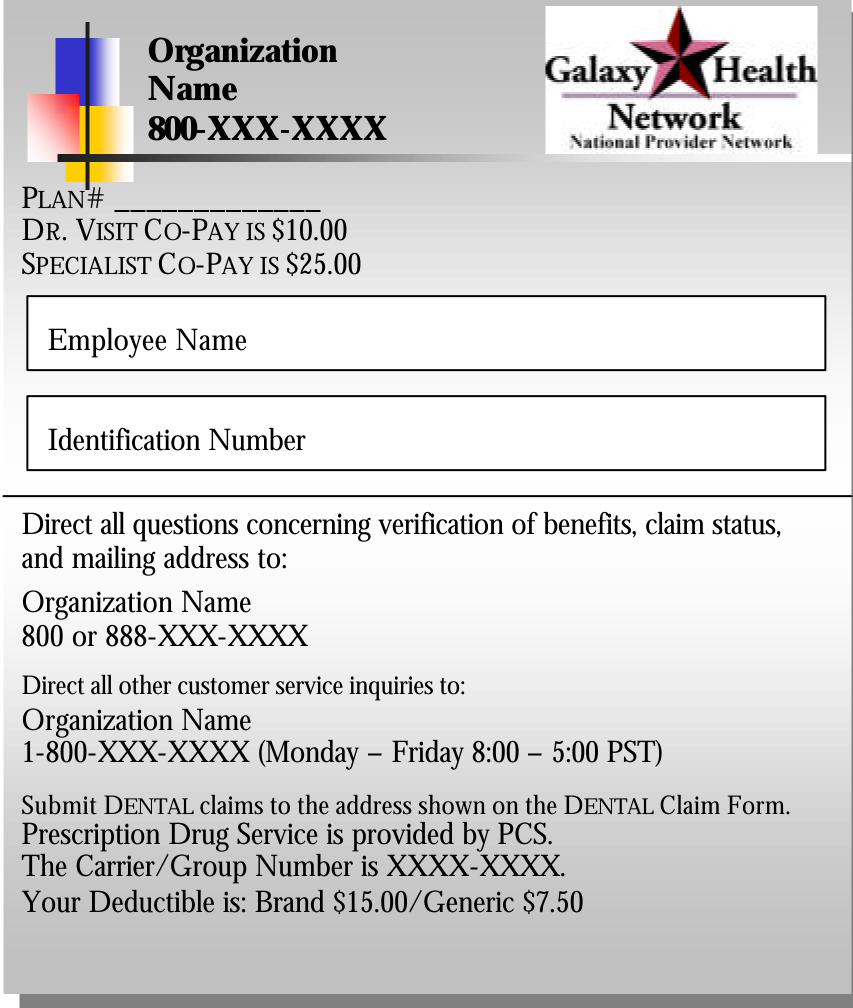


(back)



SAMPLE GALAXY PREFERRED PROVIDER ORGANIZATION ID CARD

(Exterior)



Organization Name
800-XXX-XXXX

Galaxy Health Network
National Provider Network

PLAN# _____________
DR. VISIT CO-PAY IS $10.00
SPECIALIST CO-PAY IS $25.00

Employee Name

Identification Number

Direct all questions concerning verification of benefits, claim status, and mailing address to:

Organization Name
800 or 888-XXX-XXXX

Direct all other customer service inquiries to:

Organization Name
1-800-XXX-XXXX (Monday – Friday 8:00 – 5:00 PST)

Submit DENTAL claims to the address shown on the DENTAL Claim Form.
Prescription Drug Service is provided by PCS.
The Carrier/Group Number is XXXX-XXXX.
Your Deductible is: Brand $15.00/Generic $7.50

(Interior)

Pre-Authorization Review

1. ALL HOSPITAL ADMISSIONS, OUT--PATIENT SURGERIES AND CERTAIN HEALTH CARE SERVICES require pre-authorization review. Please consult your benefits booklet for exact details. To obtain your Pre-Authorization Review, either you or your physician's office should call:

Organization Name
1-800-XXX-XXXX

2. All EMERGENCY HOSPITAL ADMISSIONS must be reported to Organization by you, a family member, your physician or hospital personnel within 48 hours (72 hours on holidays and weekends) of admission.

3. Call Organization with any questions on the above.

In order to receive maximum health benefits, you must use a Network healthcare provider. Refer to your Directory or call for a Network Physician. When you use a Network Physician simply:

1. Show you ID card each time you seek medical care;
2. Authorization payment of Benefits to the Physician; and
3. Remind your Physician to send your claim directly the Organization.

Refer to your Provider Directory or call (800) 975-3322 and ask for a Galaxy Health Network Member Service Representative.
Submit all Medical Claims to:

Galaxy Health Network
Attn: Claims Department
P.O. Box 201425
Arlington, TX 76006-1425

SAMPLE

“GALAXY MEDICAL SAVINGS NETWORK”

ID CARD

(front)

(back)