Member Reimbursement Form for Medical Claims

NOTE: Prescription Drugs with a date of service 1/1/16 and after need to go to OptumRx for processing. Please complete the OptumRx Claim form.



ONE FORM PER PATIENT PER PROVIDER

Please print clearly, complete all sections and sign. Retain copy for personal records.

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1. Patient's (Las		(First)	(Middle)	2. Patient's Member I.D. # 3. Patient's Date of Birth:					
4. Subscribe (Las		(First)	(Middle)	5. Subs			's Relationship to □ Spouse □ Ch		
7. Patient's Address:					8. Patie	8. Patient's type of insurance:			
					□НМС	HMO □ Options/Alliant □ PPO □ Medicare			
age of 18) w 1. Pare 2. Pare 3. The pare	when the reque ent is not enrol ent does not re	nation: This must be desting Parent meets be led in the same Kaise side in the same hourent will need to includes a led in the same hourent will need to include the same hourent will need to include the same hourent will need to include the same had been also be same the same th	oth of the follow or Permanente p sehold as the s ude a copy of th	wing requi blan as the ubscriber i ne divorce	rements: child under the decree o	child's Kai	ser Permanente p I plan indicating th	lan	
Custodian Requesting Reimbursement Name:				Custodian Requesting Reimbursement Contact Phone #:					
Address pay									
If your o	child is covered	l under two or more h	ealth plans, state	e law detei	mines the	e order of b	enefits for process	sing claims.	
10. Practitioner Information:			11. Provider Information: Provider's Name:			12. Condition was related to:			
Attending Practitioner's Name:					,	A. Patient's Employment? L&I			
Referring Practitioner's Name:			Provider's Tax I.D. #:			B. Auto Accident? □ Yes □ No			
			Provider's Billing Address:						
							C. Date of Incident:		
		tion must be obtaine rovider. Do not send					your itemized		
Dates of Service	(Office, ER, U	e of Service Irgent, Hospital, Clinic, Ambulance, Home)	Diagnosis (Code	Procedur	e Codes	Units / Days	Amount Paid	

14. Foreign Claims:										
For services out of country, please provide name of country:										
Where services were rendered: □ Office/ Clinic □ ER □ Urgent Care □ Hospital □ Pharmacy Please explain injury or illness:										
Itemized bills, receipts, and statements must be translated prior to submittal. Translation will be at the members expense. All Inpatient claims must be submitted with translated chart notes.										
15. I have attached one of the	16. Information about payment(s) made:	17. Other Insurance information:								
following proof of payments: ☐ The front and back of the cleared	Was there a discount for the services? ☐ Yes ☐ No	Is the patient covered by another health plan? Yes No								
check written to the provider, or bank encoded copy of the front check written to the provider.	If Yes, is the amount paid after the discount?	Subscriber name for other insurance:								
☐ A copy of a credit card statement that includes the charges and the provider's name.	Is there a balance due? ☐ Yes ☐ No	Name of other insurance company:								
☐ A copy of the receipt, with the provider's name and address preprinted on the receipt.		Did other insurance make a payment? ☐ Yes ☐ No								
Note: Itemized statements/ invoices do not count as proof of payment.	Note: If there is a balance due to the provider you may not be entitled to a refund.	If yes, include Explanation of Benefits from other insurance plan(s).								
18. Signature is required: I attest that the above information is true and accurate, and the services were received and paid for in the amount requested as indicated above. I acknowledge that if any information on this form is misleading or fraudulent, my coverage may be cancelled and I may be subject to criminal and / or civil penalties for false health care claims.										
Signature: Date:										
For any questions please contact Member Services toll-free at 1-888-901-4636, (TTY Relay: 711 or 1-800-833-6388). Or visit kp.org/wa, click on "Member Services" and send an email.										

Reimbursement requests will be processed within 60 days of receipt.

Itemized receipts, invoices, and proof of payment must be submitted, otherwise form may be sent back for lack of information.

Submit all documents to: Claims Processing

Kaiser Permanente P.O. Box 30766

Salt Lake City, UT 84130-0766

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Please complete all items on the claim form. If the information requested does not apply to the patient, indicate N/A (Not Applicable). Special care should be taken when completing the following sections:

- **10. Practitioner Information** Please fill out attending practitioner's name with the physician that was seen for services. Please fill referring practitioner's name with the physician that referred you if applicable.
- 11. **Provider Information** Please fill out provider name with the name of the facility that was visited. Please fill out Provider Tax ID with the facility's Tax ID (this number will need to be obtained from the provider). Please fill out provider billing address with the facility's address.
- **12.** Condition was related to Please indicate if the injury or reason of visit was related to your employment (L&I), or an auto accident, and if yes to either of them please indicate the date of accident.
- **13. Itemization** This information must be obtained from your provider, or must be included on your itemized statement from your provider. If this information is included on your itemized statement you can state please review attached itemized statement.
- 14. Foreign Claims Please complete this section if your services were completed outside of the country, otherwise indicate N/A.
- 15. Proof of payment Please indicate what type of proof of payment you have attached with this form.
- 16. Payment information Please answer each question by checking the box that applies to the payment(s) you made to the provider.
- 17. Other insurance Please indicate whether you have coverage from another insurance, if applicable the name of the subscriber for the other insurance and the name of the other insurance, and indicate by checking the box if they made a payment.
- 18. Signature This form must be signed and dated by either the subscriber or the patient.