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.

KAISER PERMANENTE®

ONE FORM PER PATIENT PER PROVIDER

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

1. Patient's Name: (Last) (First) (Middle)	2. Patient's Member I.D. #	3. Patient's Date of Birth: _____ Patient's Sex: ☐ M ☐ F
4. Subscriber's Name: (Last) (First) (Middle)	5. Subscriber Member I.D. #	6. Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other
7. Patient's Address:		8. Patient's type of insurance: ☐ HMO ☐ Options/Alliant ☐ PPO ☐ Medicare

9. **Custodial Parent Information:** This must be completed for reimbursement requests from a Parent for a child (under the age of 18) when the requesting Parent meets both of the following requirements:

1. Parent is not enrolled in the same Kaiser Permanente plan as the child
2. Parent does not reside in the same household as the subscriber under the child's Kaiser Permanente plan
3. The requesting parent will need to include a copy of the divorce decree or parenting plan indicating the custodial parent if not the subscriber.

Legal Custodian's Name: _____

Legal Custodian's Contact Phone #: _____

Custodian Requesting Reimbursement Name: _____

Custodian Requesting Reimbursement Contact Phone #: _____

Address payment is to be mailed to: _____

If your child is covered under two or more health plans, state law determines the order of benefits for processing claims.

10. Practitioner Information: Attending Practitioner's Name: _____ Referring Practitioner's Name: _____	11. Provider Information: Provider's Name: _____ Provider's Tax I.D. #: _____ Provider's Billing Address: _____	12. Condition was related to: A. Patient's Employment? L&I ☐ Yes ☐ No B. Auto Accident? ☐ Yes ☐ No C. Date of Incident: _____

13. The following information must be obtained from your provider, or must be included on your itemized statement from your provider. Do not send originals as they will not be returned to you.

Dates of Service	Place of Service (Office, ER, Urgent, Hospital, Clinic, Pharmacy, Ambulance, Home)	Diagnosis Code (DX)	Procedure 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 following proof of payments:

- ☐ The front and back of the cleared check written to the provider, or bank encoded copy of the front check written to the provider.
- ☐ A copy of a credit card statement that includes the charges and the provider's name.
- ☐ A copy of the receipt, with the provider's name and address preprinted on the receipt.

Note: Itemized statements/ invoices do not count as proof of payment.

16. Information about payment(s) made:

Was there a discount for the services?
☐ Yes ☐ No

If Yes, is the amount paid after the discount?
☐ Yes ☐ No

Is there a balance due?
☐ Yes ☐ No

Note: If there is a balance due to the provider you may not be entitled to a refund.

17. Other Insurance information:

Is the patient covered by another health plan? ☐ Yes ☐ No

Subscriber name for other insurance:

_____

Name of other insurance company:

_____

Did other insurance make a payment?
☐ Yes ☐ No

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 34585
Seattle, WA 98124-1585

Member Reimbursement Form for Medical Claims

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.