Health Plans

Claim Form

USE SEPARATE FORM FOR EACH PATIENT

General instructions: Make sure you and your physician or other health care professional fill out this form completely in order for you to receive timely reimbursement for paid medical services.

- Type or print requested information.
- Ask your provider(s) to help you complete all information in sections C and D.
- Attach itemized receipts or claim forms for each service. (Do not staple items.)
- A separate reimbursement request form should be completed for each patient.
- Please keep a copy of each itemized bill or receipt for your records.
- Do not submit a form if your physician or other health care professional is also filing a claim to IU Health Plans for the same service.

GROUP NO. (FROM I.D. CARD)

MEMBER IDENTIFICATION NO. (FROM I.D. CARD)

A. PATIENT INFORMATION

PATIENT NAME (Print) ______________________ SEX ☐ M ☐ F BIRTHDATE _______

RELATIONSHIP TO EMPLOYEE : ☐ SELF ☐ CHILD ☐ SPOUSE ☐ OTHER ________________

B. EMPLOYEE INFORMATION

EMPLOYEE NAME ______________________ Check if new address ☐

EMPLOYEE ADDRESS______________________City______________State_________ Zip___________

C. PROVIDER INFORMATION

PROVIDER NAME______________________TAX ID NUMBER________________NPI NUMBER__________________

PROVIDER ADDRESS______________________City______________State_________ Zip___________

D. SERVICE INFORMATION

Date (mm/dd/yy)	Place of Service	Codes for procedures, services or supplies	Diagnosis Code	Charges	Number of Units
				Total Charges	**Amount paid by you**

Over (please complete both pages) →

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E. OTHER INSURANCE INFORMATION

IS PATIENT COVERED BY ANOTHER MEDICAL PLAN? ☐ YES ☐ NO

IF YES, INDICATE MEDICAL PLAN NAME ____________________ POLICY NUMBER ____________

IDENTIFICATION NUMBER ____________________ EFFECTIVE DATE OF COVERAGE ____________

NAME, ADDRESS AND PHONE # OF OTHER CARRIER ____________________

EMPLOYER'S NAME ____________ Phone ____________ EMPLOYEE BIRTH DATE ____________

SPOUSE'S BIRTH DATE ____________

IF YOU ARE ELIGIBLE FOR MEDICARE:

- Submit bills for all charges except prescription drugs to Medicare first. Make sure you keep a copy of the itemized bill, since you will also need to submit it to IU Health Plans.
- You will receive the Explanation of Benefits Statement from Medicare, indicating payment or denial of your claim submission. Submit the Medicare statement and a copy of itemized bill to IU Health Plans.
- Some physicians and other medical providers will file your Medicare claims directly for you. You need to tell them to send you a copy of the itemized bill also, since you need to send it to IU Health Plans once you receive Medicare's Explanation of Benefits.

F. PATIENT AUTHORIZATION

To all physicians and other medical professionals, hospitals and other medical care institutions, and to insurers, medical or hospital service and prepaid health plans, employers and group policyholders, contract holders or benefit administrators:

- You are authorized to provide any benefit plan administrators, consumer reporting agencies, attorneys and independent claim administrators acting on IU Health Plans' behalf, with information regarding the Patient. This information will be used for the purpose of evaluating and administering claims for benefits.
- I hereby authorize IU Health Plans to provide the information relating to medical services and treatment rendered to me and/or my dependents.
- I understand that the duration of the authorization is for the term of coverage of the policy or contract under which a claim for health benefits has been submitted. I understand that I have a right to receive a copy of this authorization upon request. I agree that a photographic copy of this authorization is as valid as the original.
- I have furnished the information on this form so that IU Health Plans may consider this claim. By signing below, I certify the information is correct and the expenses were incurred by the patient named above.
- Should there be an overpayment in excess of the amount payable under the Medical Plan, I agree to reimburse IU Health Plans to the extent of the overpayment.

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE RELATIONSHIP OF AUTHORIZED PERSON DATE

G. PAYMENT AUTHORIZATION

PAY TO PROVIDER

☐ I authorize benefits to be paid directly to the physician or other provider of service.

EMPLOYEE / RETIREE / SURVIVOR SIGNATURE DATE

PAY TO ME

☐ I authorize benefits to be paid to me. I understand it is my responsibility to pay the physician, hospital, or other provider of service.

EMPLOYEE / RETIREE / SURVIVOR SIGNATURE DATE

Before you submit your claim…..

1. Be sure that all fields are completed.
2. Make photocopies of all receipts and completed forms. Receipts will not be returned.
3. Write your IU Health Plans Member ID number on all paperwork you submit.

SUBMIT TO

IU Health Plans
P.O. Box 11196
Portland, ME 04104-7196