HealthPlan Services (Payor ID # 59143)

Third Party Administrator for Kaiser Permanente Alternate Medical, Comprehensive Medical, Supplemental Medical, and PPO Plans

HEALTH BENEFIT CLAIM

Group Number Q-9

IMPORTANT: Please read the following before completing this form. Please print in ink.

Submit one claim form per patient. **All** fields must be completed for the claim to be processed. Attach itemized bills from your hospital, doctor, or pharmacy. The bills should include the patient's name, diagnosis, date of service, type of service and charge. Keep a copy of this completed form and bills for your records. **Note:** All claims must be filed within one year from date of service.

You may mail or fax your completed claim form:

MAIL: HealthPlan Services - Payor ID # 59143
P.O. Box 30537
Salt Lake City, UT 84130-0537

FAX: 1-877-779-9873 (please do not include a cover sheet).

If you have questions, please call **1-800-216-2166**.

EMPLOYEE / RETIREE DATA

EMPLOYEE NAME LAST FIRST MIDDLE			EMPLOYEE'S HealthPlan Services MEMBER ID# (e.g. Q91234567) - see claim instructions below
HOME ADDRESS STREET			WORK PHONE NUMBER ( )
CITY	STATE	ZIP CODE	HOME PHONE NUMBER ( )

PATIENT DATA

PATIENT NAME LAST FIRST MIDDLE			SEX ❑ MALE ❑ FEMALE
DATE OF BIRTH	AGE	DISABLED DEPENDENT? ❑ YES ❑ NO	RELATIONSHIP TO EMPLOYEE ❑ SPOUSE ❑ DOMESTIC PARTNER ❑ DEPENDENT CHILD ❑ OTHER

WERE THESE CHARGES INCURRED AS A RESULT OF AN ON-THE-JOB ILLNESS OR INJURY? ❑ YES ❑ NO OTHER ACCIDENT? ❑ YES ❑ NO

IF CLAIM IS THE RESULT OF ANY KIND OF ACCIDENT OR INJURY, COMPLETE THE FOLLOWING INFORMATION: DATE OF INJURY: _____ TIME: _____

DESCRIPTION OF WHAT HAPPENED: _____

OTHER INSURANCE DATA – PLEASE SEE INSTRUCTIONS FOR OTHER COVERAGE BELOW

IS THIS PATIENT EMPLOYED? ❑ YES ❑ NO	IF YES, GIVE NAME AND ADDRESS OF EMPLOYER BELOW

IS THIS PATIENT OR ANY FAMILY MEMBER COVERED BY OTHER GROUP HEALTH INSURANCE? ❑ YES ❑ NO IF YES, PLEASE PROVIDE INFO BELOW.

NAME OF INSURED	NAME / ADDRESS OF INSURANCE COMPANY	CERTIFICATE / GROUP NO.

IS THE PATIENT COVERED BY MEDICARE? ❑ YES ❑ NO

PHYSICIAN OR SUPPLIER INFORMATION

PHYSICIAN'S / SUPPLIER'S BILLING NAME, ADDRESS, AND PHONE NUMBER	PHYSICIAN / SUPPLIER FEDERAL TAX I.D. NUMBER ❑ SSN ❑ EIN
	PATIENT'S ACCOUNT NUMBER

DIAGNOSIS OR NATURE OF ILLNESS / INJURY: RELATE ITEMS 1, 2, 3, or 4 TO THE DIAGNOSIS CODE BOX BELOW BY ENTERING THE ITEM NUMBER FOR EACH SERVICE

1. _____ 3. _____
2. _____ 4. _____

DATE(S) OF SERVICE FROM MO	DY	YR	THROUGH MO	DY	YR	PLACE OF SERVICE	PROCEDURES, SERVICES, OR SUPPLIES CPT / MODIFIER	DIAGNOSIS CODE	FULLY DESCRIBE PROCEDURE	DAYS OR UNITS	CHARGES

PHYSICIAN / SUPPLIER SIGNATURE (including degrees and/or credentials) DATE	TOTAL CHARGES	AMOUNT PAID	BALANCE DUE
	$	$	$

AUTHORIZATIONS

PLEASE MAKE PAYMENT DIRECTLY TO: ❑ **Hospital** ❑ **Doctor** ❑ **Me** ❑ **Other (Please specify)**

PLEASE SIGN BELOW TO AUTHORIZE PAYMENT

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE: **DATE:**

AUTHORIZATION SIGNATURE FOR INFORMATION RELEASE: I hereby authorize any health care provider that provided services in connection with this claim to disclose to HealthPlan Services and any other source of coverage for those services, medical records and information pertaining to the services and patient identified in this claim, for the purpose of adjudication and payment of the claim. I understand that treatment, payment, enrollment, and/or eligibility for benefits may not be conditioned on my providing or refusing to provide this authorization. This authorization is effective immediately and shall remain in effect for one year, unless a different date is specified here _____. This authorization may be revoked by the patient at any time, effective upon receipt, except to the extent that a disclosing party or others have acted in reliance upon this authorization. I understand that the recipient of information may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law. A copy of this authorization is as valid as the original. The patient has a right to a copy of this authorization.

AUTHORIZED PERSON'S SIGNATURE: (Parent if child is under age 13)

INSTRUCTIONS FOR OTHER COVERAGE

If the patient has coverage under any other plan, you may be able to receive reimbursement from both plans. This may happen if both spouses or domestic partners (where applicable) work and both carry family coverage through their respective employers or have other coverage. In addition to the information listed below, be sure to attach copies of itemized bills and receipts.

If you (the employee) are the patient: 1) Send the original claim to HealthPlan Services, and keep a copy for your records. 2) After receiving payment, send a copy of the original claim and a copy of the *Explanation of Benefits* from HealthPlan Services to the other insurance company.

If your spouse or domestic partner is the patient: 1) Send the original claim to the other insurance company, and keep a copy for your records. 2) After receiving payment, send a copy of the original claim and of the *Explanation of Benefits* from the other insurance company to HealthPlan

If a child is the patient and you (the employee) have a birthday which falls earlier in the year than your spouse or domestic partner, or if you and your spouse are divorced or separated and you have custody: Follow the "If you (the employee) are the patient" instructions above. If your spouse or domestic partner's birthday falls earlier in the year or if you and your spouse are divorced or separated and (s)he has custody, follow the "If your spouse or domestic partner is the patient" instructions.

HOW TO FILE YOUR CLAIM

1. Complete the Employee/Retiree Data section of the form. The HealthPlan Services Member ID # begins with "Q9" and can be found on your plan identification card (if provided), or by calling HealthPlan Services Customer Service at **1-800-216-2166**.
2. Complete the Patient Data section.
3. Complete the Other Insurance section.
4. Complete the Physician or Supplier Information section, including the following:
    a. Name, address, and Tax ID number of the provider who performed the service.
    b. The diagnosis description and ICD-9/ICD-10 diagnosis code.
    c. The service provided with the CPT/HCPCS/Revenue codes.
    d. All necessary documentation supporting medical necessity.
    e. Include the signature of the physician/supplier.
5. Complete and sign the Authorizations section.
6. Mail or fax the completed claim form and all supporting documentation (including itemized bills):

MAIL: HealthPlan Services - Payor ID # 59143
P.O. Box 30537
Salt Lake City, UT 84130-0537

FAX: **1-877-779-9873** (please do not include a cover sheet)

If you have questions, please call **1-800-216-2166**.

Note: All claims are subject to medical necessity guidelines; some claims require that a Denial of Service letter from Kaiser be submitted as well. Refer to your plan brochure, *Summary Plan Description*, or plan document for additional information. If you have questions, please call HealthPlan Services Customer Service at **1-800-216-2166**.

Any person who knowingly files a statement of claim containing any misrepresentation or false, incomplete, or misleading information, or omits a material fact, may be subject to civil or criminal prosecution and penalties.