Medical Services Claim Form

Use this form to submit a claim for service(s) covered under your health plan if an out-of-network provider can't submit a claim on your behalf. Complete all sections of this form and attach the required documentation of your expenses. See the "How to Complete the Medical Services Claim Form" section to successfully submit your claim. Please use one form per medical claim.

If you have questions, contact Member Services at the number listed on your member ID card (TTY: **711**).
Note: Liability for your claim will be determined based on your plan and the information you submit.

❍ This is a foreign claim submission

A SUBSCRIBER INFORMATION — see "How to Complete the Medical Service Claim Form" section for instructions

Last name:	First name:	Middle initial:	Date of birth (MM/DD/YYYY):
Member ID number:		Group/Policy number:	
Street address:	City:	State:	ZIP code:

B PATIENT INFORMATION

Last name:	First name:	Middle initial:	Date of birth (MM/DD/YYYY):
Relationship to subscriber:			Gender: ❍ Male ❍Female
Street address:	City:	State:	ZIP code:

C OTHER INSURANCE INFORMATION

Is the patient covered by another health plan?

❍ Yes ❍ No If yes, please complete the following and provide the Explanation of Benefits (EOB) from the other health plan company. If you don't have an EOB, please submit your claim to the other health plan company first.

Name of person carrying other insurance:	Date of birth (MM/DD/YYYY):
Employer name (if applicable):	Member ID number:

D	CLAIM INFORMATION

Reason for treatment (i.e. Illness/injury):

Place of service:

❍ Office ❍ Hospital — outpatient ❍ Urgent care ❍ Emergency room ❍ Home ❍ Other___________

❍ Hospital — inpatient: Date of admission _______________ Date of discharge: ___________________

Date(s) of service (MM/DD/YYYY):	Diagnosis code(s):	Service code(s):	Modifier:	UOS / MOS:	Billed amount $:
Date(s) of service (MM/DD/YYYY):	Diagnosis code(s):	Service code(s):	Modifier:	UOS / MOS:	Billed amount $:
Date(s) of service (MM/DD/YYYY):	Diagnosis code(s):	Service code(s):	Modifier:	UOS / MOS:	Billed amount $:
Date(s) of service (MM/DD/YYYY):	Diagnosis code(s):	Service code(s):	Modifier:	UOS / MOS:	Billed amount $:
Date(s) of service (MM/DD/YYYY):	Diagnosis code(s):	Service code(s):	Modifier:	UOS / MOS:	Billed amount $:
Date(s) of service (MM/DD/YYYY):	Diagnosis code(s):	Service code(s):	Modifier:	UOS / MOS:	Billed amount $:

Member paid amount (U.S. $):

$

E	PROVIDER INFORMATION

Facility / Billing provider information

Name:			
Provider street address:	City:	State:	ZIP code:
Provider Federal Tax Identification Number (TIN):	National Provider Identifier (NPI):		

Physician / Servicing provider information

Name:			
Provider street address:	City:	State:	ZIP code:
National Provider Identifier (NPI):			

F	**FOREIGN CLAIM TRAVEL INFORMATION** (Complete only if services were received outside of the US or US territories)			
	Date you left U.S. (MM/DD/YYYY):	Intended duration of trip:	U.S. departure airport/Cruise Port:	U.S. return airport/cruise port:
	Purpose of trip:			
	Description of foreign address at time of medical treatment: ❍ Hotel ❍ Resort ❍ Other_____			
	Name of hotel or resort:			
	Street address:	City:	State:	ZIP code:
	Did you seek treatment due to an emergency? ❍ Yes ❍ No			
	Consider your visit an emergency if your condition required immediate treatment (generally provided at the onset of a condition) to: • Preserve your life • Prevent serious impairment to your bodily functions, organs, or parts • Prevent placing your physical or mental health in serious jeopardy **Note:** Scheduled visits and follow-up visits aren't considered an emergency.			
	What prompted you to seek medical care?			
	Please provide details of accident or illness			
	Name and address of witnesses			
	Date of accident or illness began			

I certify that all information provided on this claim form is accurate to the best of my knowledge. I also certify, the patient for whom this claim is made, is insured under the plan and the service(s) is for the sole use of the named patient. I request any payment that may be made be issued directly to me. I also certify, to the best of my knowledge, the expenses I am submitting meet the requirements of qualified expenses as covered by my plan. I further certify that these expenses are not reimbursable under any other plan and have not been reimbursed by any other plan.

Authorization: On behalf of myself and any patient named on this claim form ("Us"), I authorize any health care professional or entity, employer, union, insurance company, health maintenance organization, other health plan company or prepayment organization to give Medica Health Plan Solutions and my employer, or any of their designees, any and all records or information pertaining to medical history or services rendered to Us for evaluation of this claim, and for any analytical or research purposes. This authorization will automatically expire one year from the date of signature unless I revoke it sooner.

A person who files a claim with the intent to defraud or helps commit fraud against an insurer is guilty of a crime.

Please check to see that this form has been properly completed and signed before submitting for reimbursement.

G	SIGNATURE	
	Subscriber signature:	Date:

H	REQUIRED DOCUMENTATION
	❍ Proof of payment in full ❍ A provider bill on letterhead, itemizing the service(s) you received, including, but are not limited to, the date of service, place of service, procedure and diagnosis code(s), and charge amount by line ❍ Other insurance — if you selected "YES" provide the Explanation of Benefits from the other insurance carrier. ❍ Foreign Claim: Submissions must also provide proof of travel ❍ Foreign Claim: Submissions must also provide medical records **Note:** ALL Foreign Claim documentation must be translated to English ❍ Total number of pages attached: _____

Mail your completed and signed Medical Services Claim Form and required documentation to the address below.

Medica
PO Box 56099
Madison, WI
53705-9399

If you have any questions or need assistance completing the form, please call the Customer Care Center at the number on your ID card. Monday - Thursday: 7:30am - 5pm, Friday: 8am - 4:30pm.

How to Complete the Medical Services Claim Form

Section A – Subscriber information: Please complete this entire section. The subscriber is the person who holds the medical plan coverage. The member ID number is shown on the front of the medical plan membership card.

Section B – Patient information: Please complete this entire section. The patient is the member who received the medical services for which you are requesting reimbursement.

Section C – Other insurance information: Provide the information if you have other health care coverage under another plan.

Section D – Claim information: Please complete this entire section for the medical expenses for which you would like considered. If you have questions about the information needed to complete this section, please contact your health care provider's billing department for assistance. They will be able to assist you with the information you need.

- Place of service: Check a box to indicate whether you received the service at a doctor's office, a hospital as an outpatient, an urgent care, an emergency room, in the home, a hospital as an inpatient (including admit and discharge dates), or at another location
- Date of service: The date you received the medical services or made the purchase.
- Diagnosis code: A code used to identify diseases, disorders, and other reasons for patient encounters. Must be in ICD or CM format. Multiple diagnosis codes may be submitted on a single claim. If using this form to submit a dental claim, you do not need to fill in the diagnosis code.
- Service code: A code used to identify the procedure, service, or supply received from a medical provider.
- Modifier: A 2-digit code used in addition to the Service Code to indicate that a service, or supply was distinct or independent from other services performed on the same day.
- UOS/MOS (Unit of Service / Minute of Service): The number of medical visits or procedures, units of anesthesia time, oxygen volume, items or units of service, etc.
- Billed amount $: The dollar amount charged for medical services rendered for each service code.
- Member paid amount (U.S. $): The dollar amount you paid to the provider. This dollar amount must match the amount on your proof of payment.

Section E – Provider information: Please complete this entire section.
Facility/Billing provider information and Physician/Servicing provider information: Supply the following information about the physician who provided the service and the facility where the service was provided at. If you have questions about the information required to complete this section, please contact your health care provider's billing department for help. They can provide the information you need.

- Provider name: Complete legal name of institution, corporate entity, practice or individual provider.
- Provider address: The number, street, city, state, and ZIP code where the provider is located.
- Provider Federal Tax Identification Number (TIN): A Federal Tax Identification Number, also known as an Employer Identification Number (EIN), used to identify a business entity, in the U.S.
- National Provider Identifier (NPI): The NPI is a unique, 10–digit identification number given to health care providers and facilities, in the U.S. The facility NPI and the physician NPI will be different numbers.

Section F – Foreign claim travel information: Provide your travel schedule, reason for traveling, where you stayed, and details regarding the reason for seeking medical treatment.

- Date you left U.S.A: The date you left the U.S.
- Intended duration of trip: How long you planned to travel.
- U.S. departure airport or cruise port: Provide the name of the airport or cruise port where you departed the U.S.
- U.S. return airport or cruise port: Provide the name of the airport or cruise port where you returned to the U.S.

- Purpose of trip: Reason for traveling outside of the U.S.
- Name of hotel, resort, or description of foreign address at time of hospital confinement: Where you stayed or who you visited and the address.
- Did you seek treatment due to an emergency? Indicate if the reason for seeking medical treatment was due to an emergent event.
- What prompted you to seek medical care? Provide detail as to what initiated you to seek medical care.
- Please provide details of accident or illness: Provide the detail of your reason for seeking medical care.
- Name and address of witnesses: Provide contact information for witnesses of your accident/illness.
- Date of accident or illness began: Provide the date your accident occurred or the date your illness first began.

Section G – Signature: Review the legal language, then sign and date the medical services claim form.

Section H – Required documentation: When submitting this medical services claim form, you must include:
- Proof of payment in full: Documentation showing your payment to the provider for the total amount billed, for example: a canceled check or receipt from a credit card or cash payment receipt.
- Itemized provider bill: A provider bill on letterhead, itemizing the service(s) you received, which include, but are not limited to, the date of service, place of service, procedure and diagnosis code(s), charge amount by line.
- Foreign claim submissions – Proof of travel: Documentation showing your date(s) and location(s) of travel; for example: airline ticket receipt, boarding pass, itinerary, hotel bill, or travel visa.
- Total number of pages attached: Indicate how many pages of documentation you are attaching to the Medical Services Claim Form.

Proof of payment in full and an itemized statement can be obtained from your billing provider. Balance due statements are not acceptable proof of payment. Without the required documentation, your expense can't be considered for processing. Documentation submitted with your claim will not be returned.

Your claim must be submitted within 365 days from the date of services being performed.

Discrimination is Against the Law

The Health Plan complies with applicable Federal civil rights laws and will not discriminate against any person based on his or her race, color, creed, religion, national origin, sex, gender, gender identity, health status including mental and physical medical conditions, marital status, familial status, status with regard to public assistance, disability, sexual orientation, age, political beliefs, membership or activity in a local commission, or any other classification protected by law. The Health Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as: TTY communication and written information in other formats such as large print, audio, and braille.
- Provides free language services to people whose primary language is not English, such as: qualified interpreters and information written in other languages.

If you need these services, contact the number on the back of your identification card. If you believe that we have failed to provide these services or discriminated in another way on the basis of your race, color, creed, religion, national origin, sex, gender, gender identity, health status including mental and physical medical conditions, marital status, familial status, status with regard to public assistance, disability, sexual orientation, age, political beliefs, membership or activity in a local commission, or any other classification protected by law, you can file a grievance with: Civil Rights Coordinator, Mail Route CP250, PO Box 9310, Minneapolis, MN 55443-9310, 952-992-3422, TTY: 711, civilrightscoordinator@medica.com.

You can file a grievance in person or by mail, fax, or email. You may also contact the Civil Rights Coordinator if you need assistance with filing a complaint. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW Room 509F, HHH Building, Washington, D.C. 20201 800-368-1019, TTY: 800-537-7697. Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

If you want free help translating this document, call 1-877-317-2410 (TTY: 711).

Si desea recibir asistencia gratuita para la traducción de este documento, llame al 1-877-317-2410.

Yog koj xav tau kev pab dawb txhais daim ntawv no, hu rau 1-877-317-2410.

如果您需要我們免費幫您翻譯此文件，請致電 1-877-317-2410。

Nếu quý vị muốn giúp dịch tài liệu này miễn phí, gọi 1-877-317-2410.

Sanadnikun kaffaltiimaleeakkaisiniifhiikamuyoobarbaadd-an 1-877-317-2410 tiinbilbilaa.

إذا كنت ترغب في مساعدة مجانية لترجمة هذا المستند، فاتصل على الرقم 1-877-317-2410.

Если вы хотите получить бесплатную помощь в переводе этого документа, позвоните по телефону 1-877-317-2410.

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ይህን ሰነድ ለመተርጎም ነጻ እርዳታ ከፈለጉ በ 1-877-317-2410 ይደውሉ።

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T'áá jiik'é díí naaltsoos t'áá nizaadk'ehjí bee shí ká'adoowoł ninízingo kojį' hodíílnih, 1-877-317-2410.

Wenn Sie kostenlose Hilfe zur Übersetzung dieses Dokuments wünschen, rufen Sie 1-877-317-2410 an.

"यदि आप इस दस्तावेज़ का अनुवाद करने में मुफ्त सहायता चाहते हैं, तो 1-877-317-2410 पर कॉल करें"।

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