Harvard Pilgrim Health Care
P.O. Box 699183
Quincy, MA 02269
(888) 333-4742

Medical Reimbursement Claim Form for Members

To the Member

1. Please read and complete this side of the claim form.
2. Please ask your provider to read and complete the back side of the claim form or they may attach a complete and itemized bill.
3. **PLEASE SIGN ONLY ONE OF THE "ASSIGNMENT OF BENEFITS" BOXES.**
4. In states other than Massachusetts and Maine, Allianz Life is the Underwriter of out-of-network benefits for fully insured accounts.

Exclusions: Any service or supply purchased from the internet is not covered (with the exception of contact lenses).

Subscriber's First Name	Middle Initial	Last Name	
Address (Street and No.)	City	State	ZIP Code
Patient's First Name	Middle Initial	Last Name	
Member ID Number (from I.D. card)	Date of Birth (mm/dd/yyyy)	Sex: M ❑ F ❑	

Is the condition requiring treatment relating to:	**Employment** ❑ Yes ❑ No	**Auto accident** ❑ Yes ❑ No	**Injury** ❑ Yes ❑ No
Date of illness or accident	_____ mm/dd/yyyy	How and where did accident occur?	
Is the subscriber's spouse employed?	❑ Yes ❑ No	If yes, name of company	
Is patient covered by other health insurance?	❑ Yes ❑ No	If yes, name of other insurance	ID Number
Is patient covered by other dental insurance?	❑ Yes ❑ No	If yes, name of other insurance	ID Number

I hereby apply for benefits and certify that the above information is complete, true and correct. 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 policy holders, contract holders or benefit plan administrators: You are authorized to provide the Plan and any benefit plan administrators from consumer reporting agencies, attorneys and independent claim administrators acting on the Plan's behalf, with information concerning medical care, advice, treatment or supplies to the Patient, and any employment-related information regarding the Patient. This information will be used for the purpose of evaluating and administering claims for benefits. I understand that the duration of the authorization is 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.

CLAIM CANNOT BE PROCESSED WITHOUT MEMBER'S SIGNATURE

Subscriber's Signature	Date	Dependent Patient's Signature if not a minor	Date

Harvard Pilgrim Health Care includes Harvard Pilgrim Health Care, Harvard Pilgrim Health Care of Connecticut, Harvard Pilgrim Health Care of New England and HPHC Insurance Company.

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Assignment of Benefits

Payment will be made directly to the Provider, if you sign below:

I authorize payment of benefits to the physician or provider described below or as indicated on the enclosed bill. I understand that I am financially responsible to the provider for charges in excess of the plan's payment schedule or charges not covered by my benefit plan.

CLAIM CANNOT BE PROCESSED WITHOUT SUBSCRIBER'S SIGNATURE

Signed (Subscriber) _____ Date _____

OR

Payment will be made directly to you, if you sign below:

I authorize reimbursement of benefits to myself for services described below or as indicated on the enclosed bill. I understand that I am financially responsible to the provider for charges in excess of the plan's payment schedule or charges not covered by my benefit plan.

CLAIM CANNOT BE PROCESSED WITHOUT SUBSCRIBER'S SIGNATURE

Signed (Subscriber) _____ Date _____

To the Hospital - Attach fully completed UB-92 billing form **OR** attach fully itemized statement of charges and credits.

Physician's/Surgeon's Statement – Complete following or attach fully completed HCFA 1500 Form

Patient's First Name	Middle Initial	Last Name	Date of Birth

Date of illness (first symptom), injury (accident) or pregnancy (LMP):	Date first consulted for this condition:	Has patient ever had same or similar symptoms?	❑ Yes ❑ No

Date patient able to return to work:	Dates of total disability: FROM THROUGH	Dates of partial disability: FROM THROUGH

Name of referring physician or other source (e.g., public health agency)	Dates for services related to hospitalization: ADMITTED DISCHARGED

Name & address of facility where services rendered (if other than home or office)	Was laboratory work done outside your office? ❑ Yes ❑ No	Charges

DIAGNOSIS AND CONCURRENT CONDITIONS

Primary	ICD10-CM Code	Secondary	ICD10-CM Code

PLACE OF SERVICE (POS)
1 - Inpatient Hospital
2 - Outpatient Hospital
3 - Doctor's Office
4 - Patient's Home
5 - Day Care Facility
6 - Night Care Facility
7 - Nursing Homel
8 - Skilled Nursing Facility
9 - Ambulance
10 - Other Locations
11 - Independent Laboratory
12 - Other Medical/Surgical Facility
13 - Hospital Emergency Room

Services rendered FROM	TO	NO. OF SERVICES	POS	DESCRIBE EACH SERVICE SEPARATELY	PROCEDURE NUMBER	AMOUNT BILLED	DO NOT USE THESE SPACES A	AA	O	R

SIGNATURE OF PHYSICIAN OR SUPPLIER SIGNED DATE	YOUR SOCIAL SECURITY NO.	TOTAL CHARGE	AMOUNT PAID	AMOUNT DUE

YOUR PATIENT'S ACCOUNT NO.	YOUR EMPLOYER I.D. NO.	PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE AND TELEPHONE NO. I.D. NO.

AUTHORIZATIONS TO ASSIGN BENEFITS WILL NOT BE HONORED UNLESS YOUR TAX IDENTIFICATION OR SOCIAL SECURITY NUMBER IS SHOWN

PLACE OF SERVICE CODES
1 - (IH) Inpatient Hospital
2 - (OH) Outpatient Hospital
3 - (O) Doctor's Office
4 - (H) Patient's Home
5 - (PSY) Day Care Facility
6 - (PSY) Night Care Facility
7 - (NH) Nursing Home
8 - (SNF) Skilled Nursing Facility
9 - Ambulance
O - (OL) Other Locations
A - (IL) Independent Laboratory
B - Other Medical/Surgical Facility