Member Reimbursement Form for Medical Claims and Prescription Drugs

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.

GroupHealth®

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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: _____
123		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:** 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 Group Health plan as the child
   2. Parent does not reside in the same household as the subscriber under the child's Group Health plan

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:	11. Provider Information:	12. Condition was related to:
Attending Practitioner's Name:	Provider's Name:	A. Patient's Employment? L&I ☐ Yes ☐ No
Referring Practitioner's Name:	Provider's Tax I.D. #:	B. Auto Accident? ☐ Yes ☐ No
	Provider's Billing Address:	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. **Pharmacy Charges:** Please attach legible copies of receipts / dispensing list that include all of the following information:
1) Fill Date 2) Drug Name 3) Drug Strength 4) Quantity 5) Days Supply 6) Prescription Number 7) Your Cost / Amount

DA-3116 Rev. Date 2015317

15. 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.

16. 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.

17. 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.

18. 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).

19. 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 Customer Service toll-free at 1-888-901-4636, (TTY Relay: 711 or 1-800-833-6388). Or visit ghc.org, click on "Customer Service" and send an email.

Reimbursement requests will be processed within 45 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
Group Health Cooperative
PO Box 34585
Seattle, WA 98124-1585

Member Reimbursement Form for Medical Claims and Prescription Drugs Instructions

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. **Pharmacy Charges** – Please attach legible copies of receipts / dispensing lists that include fill date, drug name, drug strength, quantity, days supply, prescription number, and your cost / amount paid.
15. **Foreign Claims** – Please complete this section if your services were completed outside of the country, otherwise indicate N/A.
16. **Proof of payment** – Please indicate what type of proof of payment you have attached with this form.
17. **Payment information** – Please answer each question by checking the box that applies to the payment(s) you made to the provider.
18. **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.
19. **Signature** – This form must be signed and dated by either the subscriber or the patient.