



MEMBER REIMBURSEMENT FORM

INSTRUCTIONS:

- Fill out this form to request reimbursement for amounts you PAID the provider.
- If you have not paid the provider, **DO NOT USE THIS FORM.** Ask the provider to bill us directly using a CMS 1500 or UB-04 claim form. Make sure the provider has your Kaiser Permanente membership information.
- Fill out the form completely and sign it. Send all required documents. **Incomplete or unsigned forms will be returned to you.**
- If you are filling out the form on behalf of someone else, please attach either a Power of Attorney Form or Appointment of Representative form. Parents do not need to submit these additional forms if signing on behalf of minor children or legal dependents.
- Keep a copy of this form and all documents for your records.
- For questions or help with the form, please call Member Services at the number listed below.

SECTION A: PATIENT INFORMATION

Last Name	First Name	Initial
<input type="text"/>	<input type="text"/>	<input type="text"/>

Patient Address	City	State	Zip
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Birthdate (MM/DD/YYYY)	Medical Record Number (found on ID Card)
<input type="text"/>	<input type="text"/>

Is the patient covered under Medicare? Yes No Is this a prescription reimbursement request? Yes No

Is the patient covered under Medicaid/Medi-Cal? Yes No

Is the patient covered under both Medicare and Medicaid/Medi-Cal? Yes No

Was the service due to an auto accident? Yes No

Does the patient have other health insurance coverage? Yes No. If "Yes" complete Section B, below.

SECTION B: OTHER COVERAGE INFORMATION

Name and Address of Other Insurance	Subscriber ID Number	Group Number
	Employer Name	Insurance Telephone Number () -

SECTION C: EXPLANATION OF TREATMENT (optional)

Please describe the services you received. Explain why treatment was not done at Kaiser Permanente.

Was an ambulance used? <input type="checkbox"/> Yes <input type="checkbox"/> No	If "Yes," who called the ambulance? <input type="checkbox"/> Patient <input type="checkbox"/> Kaiser Permanente <input type="checkbox"/> Police/Fire <input type="checkbox"/> Other: _____
Was the patient admitted to the hospital? <input type="checkbox"/> Yes <input type="checkbox"/> No	If "Yes" – Admit Date (MM/DD/YYYY) <input type="text"/> If "Yes" – Discharge Date (MM/DD/YYYY) <input type="text"/>

SECTION D: REQUIRED INFORMATION FOR REIMBURSEMENT

To prevent processing delays, you **MUST** provide the following information:

- (1) **Proof of Payment: We need proof you paid the provider.** Send us your receipt, bank statement, copies of original checks (front and back), or any other documents showing how much you paid the provider; **AND**
- (2) **Provider's Bill:** Send us a copy of the provider's bill you **paid**. Please include all pages and any detailed billing statements.

Or, if you do not have a copy of the bill, please provide the following information:

Name of patient and medical record number	
Dates of service	
Name of provider (doctor, hospital, ambulance service, pharmacy, laboratory, etc.)	
Address where service was provided (hospital address, doctor address, etc.)	
Services provided to you (x-ray, office visit, injection, prescription, etc.).	
Amount billed	

Note: All documents and information submitted must be legible or the form will be returned.

SECTION E: CRUISE OR FOREIGN TRAVEL REIMBURSEMENT REQUIRED DOCUMENTS

Was the service provided during a cruise or foreign travel? Yes No; If "No" please skip. If "Yes", please provide the following information.

<input type="checkbox"/> Proof of travel: Travel documents; such as a copy of airline tickets or a travel itinerary (optional)	<input type="checkbox"/> Any related medical records, including copies of medical reports, hospital admission notes, emergency room notes, etc.
<input type="checkbox"/> Copies of original, detailed bills of service (doctor, hospital, and prescriptions)	<input type="checkbox"/> Proof of payment for services received, including prescriptions (receipt or bank statement, copies of front and back of checks, or any other documents showing how much you paid the provider)

Note: All documents and information submitted must be legible or the form will be returned.

PATIENT SIGNATURE

I certify that the information provided on this form is correct to the best of my knowledge. I authorize the release of all information related to the health care services I received on the dates listed on this form. I understand that this information is necessary to allow Kaiser Foundation Health Plan, Inc, to process my claim for payment.

PATIENT / AUTHORIZING NAME: (PARENT'S SIGNATURE IF PATIENT IS A MINOR or LEGAL DEPENDENT)

PATIENT/ AUTHORIZING SIGNATURE: (PARENT'S SIGNATURE IF PATIENT IS A MINOR or LEGAL DEPENDENT)

DATE SIGNED:

REIMBURSEMENT MAILING ADDRESS AND MEMBER SERVICE PHONE NUMBER

<u>COLORADO MEMBER</u> Claims Address P.O. Box 373150 Denver, CO 80237-9998 MEMBER SERVICES 1-303-338-3800	<u>GEORGIA MEMBER</u> Claims Address P.O. Box 370010 Denver, CO 80237-9998 MEMBER SERVICES 1-888-865-5813	<u>CALIFORNIA MEMBER - SCAL</u> Claims Address P.O. Box 7004 Downey, CA 90242-7004 MEMBER SERVICES 1-800-464-4000
<u>MD, DC OR VA MEMBER</u> Claim Address P.O. Box 371860 Denver, CO 80237-9998 MEMBER SERVICES 1-800-777-7902	<u>HAWAII MEMBER</u> Claim Address P.O. Box 378021 Denver, CO 80237-9998 MEMBER SERVICES 1-800-966-5955	<u>CALIFORNIA MEMBER - NCAL</u> Claims Address P.O. Box 12923 Oakland, CA 94604-2923 MEMBER SERVICES 1-800-464-4000
<u>NORTHWEST MEMBER</u> Claims Address P.O. Box 370050 Denver, CO 80237-9998 MEMBER SERVICES 1-800-813-2000	<u>AMBULANCE CLAIMS</u> Claims Address EMI – KP Ambulance Claims P.O. Box 853915 Richardson, TX 78085-3915	