Harvard Pilgrim Health Care

Member Reimbursement Form instructions

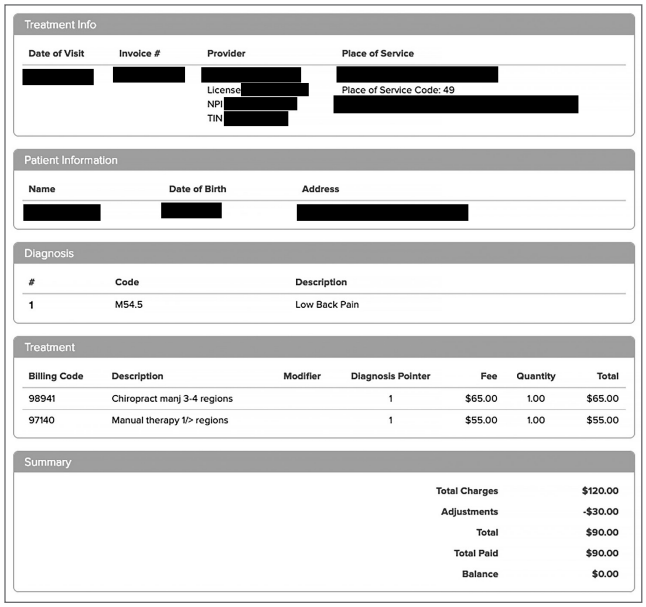
Complete and submit a separate form for each member and provider. All sections are required for the form to be processed.

To request reimbursement, the following information is required.

☑ **1. Proof of services rendered**

Attach any related claim summaries, an itemized bill, invoice from your provider or Explanation of Benefit forms you may have received for these services, including those received from other insurance companies.

EXAMPLE:



Treatment Info

Date of Visit	Invoice #	Provider	Place of Service
[redacted]	[redacted]	[redacted] License [redacted] NPI [redacted] TIN [redacted]	[redacted] Place of Service Code: 49 [redacted]

Patient Information

Name	Date of Birth	Address
[redacted]	[redacted]	[redacted]

Diagnosis

#	Code	Description
1	M54.5	Low Back Pain

Treatment

Billing Code	Description	Modifier	Diagnosis Pointer	Fee	Quantity	Total
98941	Chiropract manj 3-4 regions		1	$65.00	1.00	$65.00
97140	Manual therapy 1/> regions		1	$55.00	1.00	$55.00

Summary

Total Charges	$120.00
Adjustments	-$30.00
Total	$90.00
Total Paid	$90.00
Balance	$0.00

☑ **2. Proof of payment**

Attach any documentation that clearly shows proof of payment, such as credit card statements or receipts, copy of the front and back of the check written to provider, statement from provider indicating payment was made, a receipt of purchase items with the provider name, address and item listed as paid.

Continued ▶

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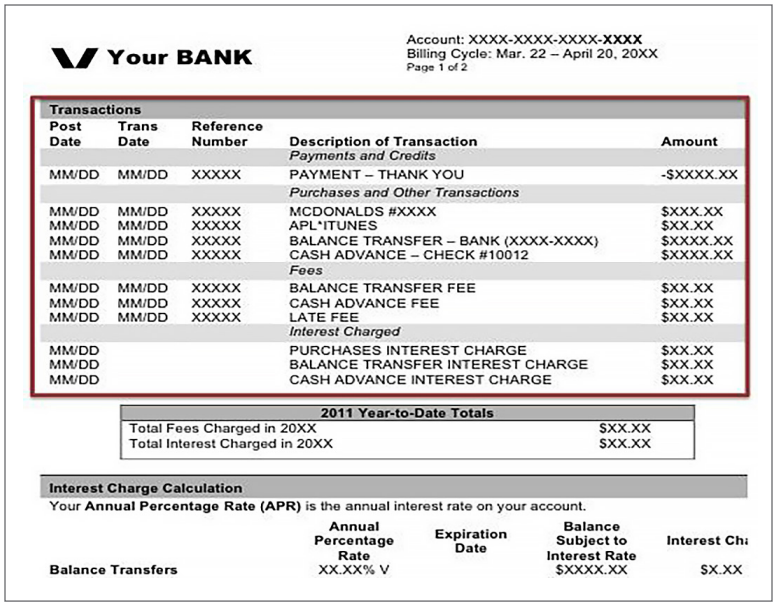
Proof of payment, *continued*

☑ For International claims paid in cash over $1,000 U.S. dollars, source of funds proof such as wire transfer, travelers check, credit card statement, etc. is required. For claims inside the U.S. paid in cash over $500 U.S. dollars, source of funds proof such as wire transfer, travelers check, credit card statement, etc. is required.

EXAMPLES:



Your BANK

Account: XXXX-XXXX-XXXX-**XXXX**
Billing Cycle: Mar. 22 – April 20, 20XX
Page 1 of 2

Transactions

Post Date	Trans Date	Reference Number	Description of Transaction	Amount
			Payments and Credits	
MM/DD	MM/DD	XXXXX	PAYMENT – THANK YOU	-$XXXX.XX
			Purchases and Other Transactions	
MM/DD	MM/DD	XXXXX	MCDONALDS #XXXX	$XXX.XX
MM/DD	MM/DD	XXXXX	APL*ITUNES	$XX.XX
MM/DD	MM/DD	XXXXX	BALANCE TRANSFER – BANK (XXXX-XXXX)	$XXXX.XX
MM/DD	MM/DD	XXXXX	CASH ADVANCE – CHECK #10012	$XXXX.XX
			Fees	
MM/DD	MM/DD	XXXXX	BALANCE TRANSFER FEE	$XX.XX
MM/DD	MM/DD	XXXXX	CASH ADVANCE FEE	$XX.XX
MM/DD	MM/DD	XXXXX	LATE FEE	$XX.XX
			Interest Charged	
MM/DD			PURCHASES INTEREST CHARGE	$XX.XX
MM/DD			BALANCE TRANSFER INTEREST CHARGE	$XX.XX
MM/DD			CASH ADVANCE INTEREST CHARGE	$XX.XX

2011 Year-to-Date Totals

Total Fees Charged in 20XX	$XX.XX
Total Interest Charged in 20XX	$XX.XX

Interest Charge Calculation

Your **Annual Percentage Rate (APR)** is the annual interest rate on your account.

	Annual Percentage Rate	Expiration Date	Balance Subject to Interest Rate	Interest Cha
Balance Transfers	XX.XX% V		$XXXX.XX	$X.XX

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☑ **3. Sign and date the completed form.**

☑ **4. Keep a copy of all bills and claim forms submitted** (submitted documentation will not be returned).

☑ **5. Mail completed claim form and all attachments to the following address:**

Harvard Pilgrim Health Care
P.O. Box 699183
Quincy, MA 02269.

Any missing or incomplete information may result in a processing delay or a denial. If you have any questions about your benefits or coverage, please check your Benefit Handbook and your Schedule of Benefits for a complete listing of benefits and requirements for coverage.

☑ **6. If submitting supporting documents at the request of HPHC, send the required documents to:**

Attn: Member Submission- Additional Claim Information
Harvard Pilgrim Healthcare
PO Box 699183
Quincy, MA 02269

Harvard Pilgrim Health Care

Is this a new claim? ☐ Yes ☐ No

Are you submitting documentation for a previously submitted claim? ☐ Yes ☐ No

Section 1 – Member who Received Services (fill out one form per member and provider)

HPHC Identification Number (from I.D. Card) including Alpha Prefix | First Name | Middle Initial | Last Name

Date of Birth (mm/dd/yyyy)

Member Address (Street and No.) | City | State | ZIP Code | Country

Section 2 – Other Insurance Information

Please complete the information below if member is covered by another insurance.
Attach any Explanation of Benefit/Explanation of Medicare Benefit or Denial letter from other insurance with the submission.

Does Member Have Other Insurance?

☐ Yes ☐ No

Other Insurance:

☐ Medicare
☐ Part A ☐ Part B ☐ Part A & B
☐ Motor Vehicle Accident
☐ Worker's Compensation
☐ Travel Insurance (outside US)
☐ Dental
☐ Other Health Insurance
☐ Other _____

Other Insurance Company Name(s):	Insurance Policy ID Number(s):

Section 3 – Claim Information

This section must be completed, and you will need your health care provider to assist in completing this section.
Services performed by multiple providers requires a separate form per provider

Services Received in the US?

☐ Yes ☐ No

Hospital/Group or Physician name

Services Received Internationally?

☐ Yes ☐ No

TIN or NPI # (not required on International submission)

Provider Address (Street and No.) | City | State | ZIP Code | Country

If services were received outside of the US:

☐ I am an expatriate or retiree living abroad.
☐ I am traveling internationally for pleasure.
☐ I am traveling internationally for business; however, live in the U.S.

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Section 3 (continued) – Type of Service

Select most appropriate service that was rendered. Refer to the Benefit Handbook for benefits and coverage.

Outpatient Services:

- ☐ Physician and other **Professional Office Visits** (Adult or Pediatric)
- ☐ Rehabilitative Services (physical, occupational, pulmonary, and cardiac rehabilitation or speech, hearing and language services)
- ☐ Lactation Consultation
- ☐ Chiropractic
- ☐ Laboratory, Radiology and other Diagnostic Services (including Genetic Testing, CT and PET Scans, MRI, MRA and Nuclear Medicine)

Inpatient Hospital Admissions:

- ☐ Acute Hospital, including Emergency Room admissions
- ☐ Skilled Nursing Facility
- ☐ Rehabilitation Facility

Other Services:

- ☐ Ambulance or Air Ambulance services
- ☐ Durable Medical Equipment/Medical Supplies/Prosthetics (including crutches, ostomy supplies and wigs)
- ☐ Hearing Aids
- ☐ Vision (Eyeglasses/Contact lenses)
- ☐ Emergency Room Services
- ☐ Observation Services (inpatient or outpatient)
- ☐ Medical Drugs (inpatient drugs and outpatient drugs with prescription coverage)

Other Service – Please describe:

_____

Section 4 – Service Information

Complete all columns in the below grid.

- Enter Date(s) of Service.
- For services received in the United States, enter the description of the procedure, services, or code OR attach the itemized bill. For international claims, enter the description of the procedure, services, or code AND submit the itemized bill.
- Enter the quantity or number of items/visits.
- Enter diagnosis code or description of the injury/illness.
- Enter the Language, Country and Currency if not U.S.
- Enter amount provider billed and amount member paid.

Submit one form per provider. Multiple services from the same provider can be included on the same form.

Examples - U.S. and International (Intl.) Claims

Date of Service (Start)	Date of Service (End)	Description of procedure, services or code	Qty or # of items/ visits	Description of diagnosis or code	Language (if not English)	Country (Intl. only)	Currency Billed (Intl. only)	Amount Billed	Amount Paid
01/01/2021	01/03/2021	Physical Therapy or 97110	3	Low Back Pain or M54.5				$123.00	$103.00
02/13/2021	02/13/2021	Office Visit or 99212	1	Headache or R51	German	Germany	Euro	€104.00	€104.00

Enter claim details below:

Date of Service (Start)	Date of Service (End)	Description of procedure, services or code	Qty or # of items/ visits	Description of diagnosis or code	Language (if not English)	Country (Intl. only)	Currency Billed (Intl. only)	Amount Billed	Amount Paid
							Total Amount		

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Section 4 (continued) – Service Information

I hereby apply for benefits and certify that the information given 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 provided 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 for 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.

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits

Member Signature (Subscriber Signature if Member is a Minor) **Date**

Section 5 – Assignment of Benefits

☐ **Please check this box if you want Harvard Pilgrim Healthcare to pay benefits directly to the doctor/provider.**

I authorize payment of benefits to the physician or provider described above 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.

Member Signature (Subscriber Signature if Member is a Minor) **Date**

Checklist

☐ I have completed and signed this form in its entirety.

☐ I have enclosed proof of payment

☐ I have enclosed proof of service

☐ I have completed one form per member and provider

Language Assistance Services

Español (Spanish) ATENCIÓN: Si usted habla español, servicios de asistencia lingüística, de forma gratuita, están a su disposición. Llame al 1-888-333-4742 (TTY: 711).

Português (Portuguese) ATENÇÃO: Se você fala português, encontram-se disponíveis serviços linguísticos gratuitos. Ligue para 1-888-333-4742 (TTY: 711).

Kreyòl Ayisyen (French Creole) ATANSYON: Si nou palé Kreyòl Ayisyen, gen asistans pou sèvis ki disponib n lang nou pou gratis. Rele 1-888-333-4742 (TTY: 711).

繁體中文 (Traditional Chinese) 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1 888-333-4742（TTY：711）。

Tiếng Việt (Vietnamese) CHÚ Ý: Nếu quí vị nói Tiếng Việt, dịch vụ thông dịch của chúng tôi sẵn sàng phục vụ quí vị miễn phí. Gọi số 1-888-333-4742 (TTY: 711).

Русский (Russian) ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуг перевода. Звоните 1-888-333-4742 (телетайп: 711).

العربية (Aral

:ه إذا أنت تتكلم ألُلْغةِ **ألعربية** ، خَدَمات ألمُساعَدة ألُلْغَوية مُتَوفرة لك مَجانا.ً **إتصل على 1 888-333-4742** (TTY: 71

ខ្មែរ (Cambodian) ប្រសុំជូនដំណឹង៖ បើអ្នកនិយាយភាសាខ្មែរ, យើងមានសេវាកម្មបកប្រែ ជូនលោកអ្នកដោយ ឥតគិតថ្លៃ។ ចូរ ទូរស័ព្ទ 1-888-333-4742 (TTY: 711)។

Français (French) ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-888-333-4742 (ATS: 711).

Italiano (Italian) ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-888-333-4742 (TTY: 711).

한국어 (Korean) '알림': 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 888-333-4742 (TTY: 711) 번으로 전화해 주십시오.

ελληνικά (Greek) ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, υπάρχουν στη διάθεσή σας δωρεάν υπηρεσίες γλωσσική υποστήριξης. Καλέστε 1-888-333-4742 (TTY: 711).

Polski (Polish) UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwo pod numer 1-888-333-4742 (TTY: 711).

हिंदी (Hindi) ध्यान दीजिए: अगर आप हिंदी बोलते हैं तो आपके लिये भाषाकी सहायता मुफ्त में उपलब्ध है. जानकारी के लिये फोन करे. 1-888-333-4742 (TTY: 711)

ગુજરાતી (Gujarati) ધ્યાન આપો : જો તમે ગુજરાતી બોલતા હો તો આપને માટે ભાષાકીય સહાય તદ્દન મફત ઉપલબ્ધ છે. વિશેષ માહિતી માટે ફોન કરો. 1-888-333-4742 (TTY: 711)

ພາສາລາວ (Lao) ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-888-333-4742 (TTY: 711).

ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call 1-888-333-4742 (TTY: 711).

General Notice About Nondiscrimination and Accessibility Requirements

Harvard Pilgrim Health Care and its affiliates as noted below ("HPHC") comply with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. HPHC does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

HPHC:

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

If you need these services, contact our Civil Rights Compliance Officer.

If you believe that HPHC has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with: Civil Rights Compliance Officer, 93 Worcester St, Wellesley, MA 02481, (866) 750-2074, TTY service: 711, Fax: (617) 509-3085, Email: civil_rights@harvardpilgrim.org. You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, the Civil Rights Compliance Office is available to help you. 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, (800) 537-7697 (TTY)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.