KAISER PERMANENTE®

Kaiser Permanente Insurance Company

MEMBER REIMBURSEMENT CLAIM FORM

INSTRUCTIONS: This form is to request reimbursement for services you've paid for out-of-pocket. For your claim to be considered for payment, follow these simple steps:

1. **Fill out this form completely and sign it.**
2. **Get an itemized bill from your provider detailing the charges (see Section B for the information needed in this bill).**
3. **Get a payment receipt for services (which can be a receipt from your provider, a copy of the check, or a bank or credit card statement).**
4. **Send the form, bill, and receipt to the address for your region in Section G.**
5. **Keep a copy of all documentation for your records.**

Contact member services with any questions about this process at the number for your region in Section G.

SECTION A: PATIENT INFORMATION

Last Name	First Name	Initial

Patient Address	City	State	Zip

Birthdate (MMDDYYYY)	Medical Record Number found on ID Card

Does the patient have other health insurance coverage? ◯ Yes ◯ No. If 'Yes" complete Section C below

Was the service due to an auto accident? ◯ Yes ◯ No If 'Yes* complete Section D below and provide all itemized bill requirements in section **B** below

SECTION B: ITEMIZED BILL REQUIREMENTS

BILLS MUST BE ITEMIZED AND INCLUDE ALL OF THE FOLLOWING INFORMATION FOR REIMBURSEMENT

- Name and address of provider (doctor, hospital, lab, ambulance service, etc.)
- Tax Identification Number (TIN)
- Amount charged for each service
- Place of service
- Procedure code
- Diagnosis code
- Name of patient
- Service provided
- Dates of service
- National Provider Identifier (NPI)
- Proof of payment: receipt or bank statement, copies of original check (front and back)

SECTION C: OTHER COVERAGE INFORMATION

If your primary coverage is through another medical plan, you must file your claim with that plan first. if there is a balance remaining, after your primary medical plan pays your claim, you may file a claim with Kaiser Permanente for the difference.

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

KAISER PERMANENTE®

Kaiser Permanente Insurance Company

MEMBER REIMBURSEMENT CLAIM FORM

SECTION D: AUTOMOBILE ACCIDENT RELATED MEDICAL SERVICES

Automobile Insurance Name and Address	Automobile Insurance Phone Number
	Was the patient a driver or passenger? ○ Driver ○ Passenger

PLEASE PROVIDE A LEGIBLE COPIES OF THE FOLLOWING DOCUMENTS:

Copy of the auto policy face sheet for the vehicle in which the patient was riding Medical records and/or reports that you may have in your possession

Please include all itemized bill requirements in section **B** above

SECTION E: FOREIGN/CRUISE TRAVEL REQUIRED DOCUMENTS

ALL BELOW DOCUMENTATION IS REQUIRED TO BE SUBMITTED FOR REIMBURSEMENT OF FOREIGN/CRUISE CLAIMS

- Proof of payment: Receipt or bank statement, copies of original
- Proof of pharmaceutical payment: Include on claim form and copies
- Proof of travel: Travel documents for example copy of travel and/or airline tickets
- Diagnosis code noted on claim form checks (front and back)
- Copies of original itemized bills of service—professional, provide hospital, and pharmaceutical
- Applicable medical records, including copies of original Itinerary medical report, admission notes and emergency notes

SECTION F: AUTHORIZING SIGNATURE

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)

SIGNATURE DATE

SECTION G: MAILING ADDRESS AND MEMBER SERVICE PHONE NUMBER

COLORADO MEMBERS **Claim Address** P.O. Box 373150 Denver, CO 80237-9998 **MEMBER SERVICES** **1-855-364-3184**	**GEORGIA MEMBERS** **Claim Address** P.O. Box 370010 Denver, CO 80237-9998 **MEMBER SERVICES** **1-855-364-3185**	**HAWAII MEMBERS** **Claim Address** P.O. Box 378021 Denver, CO 80237-9998 **MEMBER SERVICES** **1-800-238-5742**
SOUTHERN CA MEMBERS **Claim Address** P.O. Box 7004 Downey, CA 90242-7004 **MEMBER SERVICES** **1-800-788-0710**	**MD, DC OR VA MEMBERS** **Claim Address** P.O. Box 371860 Denver, CO 80237-9998 **MEMBER SERVICES** **1-888-225-7202**	**NORTHERN CA MEMBERS** **Claim Address** P.O. Box 12923 Oakland, CA 94604-2923 **MEMBER SERVICES** **1-800-788-0710**

KAISER PERMANENTE®

Kaiser Permanente Insurance Company

MEMBER REIMBURSEMENT CLAIM FORM

For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

PROVIDER REIMBURSEMENT: If your request is on behalf of your provider for provider reimbursement, please have the Provider submit charges directly to Kaiser Permanente on the CMS1500 or UB04 industry standard claim form, which is required for processing. Please ensure your provider has your Kaiser Permanente member ID number information and copy of your ID card.