INTERNATIONAL CLAIM FORM
(one patient per provider)

Harvard Pilgrim Health Care

Harvard Pilgrim reserves the right to request further information to support your claims.

Please print clearly, complete all sections and sign. Retain a copy of all receipts and documents for your records.

1. PATIENT'S HPHC ID# (FROM I.D. CARD):

___ ___ ___ ___ ___ ___ ___ ___ ___–___ ___

2. PATIENT'S DATE OF BIRTH: ___ / ___ / ___

SEX: ☐ M ☐ F

3. PATIENT'S NAME: LAST FIRST MIDDLE INITIAL

4. SUBSCRIBER'S NAME:

ADDRESS:

TELEPHONE: ( )

5. PATIENT'S RELATIONSHIP TO SUBSCRIBER:

Self ☐ Spouse ☐ Child ☐ Other ☐

6. PROVIDER'S NAME:

ADDRESS:

TELEPHONE: ( )

7. OUTSIDE THE USA:

In what country was the patient seen? _____

In what language was the bill written? _____

In what currency was the bill paid? _____

8. TYPE OF SERVICE: Please check the type of service that was rendered:

☐ Office visit
☐ Inpatient hospital care
☐ Inpatient surgery
☐ Outpatient surgery
☐ Emergency room visit
☐ Lab or x-ray services
☐ Covered prescription drugs
☐ Medical supplies
☐ Other _____

9. DIAGNOSIS: **What were you seen for?** (e.g. flu, broken arm, asthma, etc.)

Detailed description of illness or injury: _____

10.

Date(s) of service	Description of procedures, services, or supplies provided	Amount paid

11. Total Amount paid: _____

12. Provide proof of service(s) with the following:

☐ An itemized bill from the provider of service, listing dates of service, services provided, and dollar amounts paid

13. Proof of payment through one of the following: (check which method applies)

☐ Receipt of payment by provider for cash payments. Cash payments MUST also include proof for source of funds (i.e., wire transfer, travelers check receipt, credit card statement , bank statement).
☐ Financial Statement to include a copy of front and back of canceled check made out to the provider;
☐ Credit card statement including service receipt;

Please submit this form and all documentation to:
HARVARD PILGRIM HEALTH CARE CLAIMS PROCESSING
P.O. BOX 699183
QUINCY, MA 02169-9183
1-888-333-4742

14. 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 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.

FORM MUST BE SIGNED. CLAIM CANNOT BE PROCESSED WITHOUT MEMBER'S SIGNATURE.

MEMBER'S SIGNATURE DATE SUBSCRIBER'S SIGNATURE IF THE PATIENT IS A MINOR DATE

INTERNATIONAL CLAIM FORM HELP SHEET

(one per patient per provider)

Please print clearly when completing the medical claim form.

FIELD #	FIELD NAME	DESCRIPTION
1.	Patient's HPHC ID#	ID# with suffix, found on the front of the Harvard Pilgrim Health Care Plan ID card.
2.	Patient's Date of Birth Patient's Sex	Date of Birth: Month (2 digits), Day (2 digits), Year (4 digits) Sex: M = Male, F = Female
3.	Patient's Name	Last Name, First Name and Middle Initial of patient receiving services.
4.	Subscriber's Name, Address and Telephone Number	Subscriber is the person who enrolls in a Harvard Pilgrim Health Care plan and signs the membership application form on behalf of him/herself and any dependents.
5.	Patient's Relationship to Subscriber	Is the patient the subscriber, the spouse, the child or another (e.g. partner)?
6.	Provider's Name, Address and Telephone Number	A provider is the practitioner or facility that renders services. This includes, but is not limited to, hospitals, physicians, optometrists, licensed clinical social workers, DME suppliers and pharmacies.
7.	Outside the USA	Indicate in what country services were provided, in what language (if not English) the bill and proof of payment are written, and in what currency the bill was paid.
8.	Type of Service	In what setting did the patient receive treatment or care, such as office, emergency room, outpatient hospital (for x-rays, tests), inpatient hospital clinic or medical supply store?
9.	Diagnosis: What was the patient seen for?	Detailed description of illness or injury.
10.	Date(s), Description of Service and Amount Paid for Services	The date(s) the services were provided to the patient. Detailed description of procedures, services, or supplies provided, and amount paid for services.
11.	Total Amount Paid	Total amount paid for each date of services and procedures listed.
12.	Proof of Service(s)	A document from the provider listing date(s) of service(s) provided, and dollar amounts paid and charged.
13.	Proof of Payment	Documentation that validates and proves your payment.
14.	Signature	Form must be signed. Harvard Pilgrim cannot process without a signature.

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 nan 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 услуги перевода. Звоните 1-888-333-4742 (телетайп: 711).

العربية (Arabic)

إنتباه: إذا أنت تتكلم أللُغةِ **ألعربية** ، خَدَمات ألمُساعَدة أللُغَوية مُتَوفرة لك مَجاناً. **إتصل على 1 888-333-4742**

(TTY: 711)

ខ្មែរ (Cambodian) ប្រសុំជូនដំណឹង៖ បើអ្នកនិយាយភាសាខ្មែរ, យើងមានសេវាកម្មបកប្រែ ជូនលោកអ្នកដោយឥតគិតថ្លៃ។ 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. 1-888-333-4742 (TTY: 711) 번으로 전화해 주십시오.

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

Polski (Polish) UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń 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).

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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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 Officer 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.