Harvard Pilgrim Health Care UnitedHealthcare

Harvard Pilgrim Access America
P.O. Box 699183
Quincy, MA 02269
1-888-333-4742

CLAIM FORM

TO THE MEMBER

1. Please read and complete this side of the claim form.
2. Please ask your provider to read and complete the back side of the claim form or they may attach a complete and itemized bill.
3. **PLEASE SIGN ONLY ONE OF THE "ASSIGNMENT OF BENEFITS" BOXES.**

SUBSCRIBER NAME	FIRST	INITIAL	LAST

ADDRESS (STREET AND NO.)	CITY	STATE	ZIP

PATIENT'S NAME	FIRST	INITIAL	LAST

MEMBER IDENTIFICATION NO. (FROM I.D. CARD)	DATE OF BIRTH	SEX
___ ___ ___ ___ ___ ___ ___ ___ ___–___ ___	/ /	M ☐ F ☐

IS THE CONDITION REQUIRING TREATMENT RELATED TO: EMPLOYMENT	☐ YES ☐ NO	AUTO ACCIDENT	☐ YES ☐ NO	INJURY	☐ YES ☐ NO

DATE OF ILLNESS OR ACCIDENT MONTH / DAY / YEAR

HOW AND WHERE DID ACCIDENT OCCUR?

IS THE SUBSCRIBER'S SPOUSE EMPLOYED?	☐ YES ☐ NO	IF YES, NAME OF COMPANY	
IS PATIENT COVERED BY OTHER HEALTH INSURANCE?	☐ YES ☐ NO	IF YES, NAME OF OTHER INSURANCE	ID NUMBER
IS PATIENT COVERED BY OTHER DENTAL INSURANCE?	☐ YES ☐ NO	IF YES, NAME OF OTHER INSURANCE	ID NUMBER

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.

CLAIM CANNOT BE PROCESSED WITHOUT MEMBER'S SIGNATURE.

SUBSCRIBER'S SIGNATURE DATE

DEPENDENT PATIENT'S SIGNATURE DATE
IF NOT A MINOR

ASSIGNMENT OF BENEFITS

PAYMENT WILL BE MADE DIRECTLY TO THE PROVIDER, IF YOU SIGN BELOW.

I AUTHORIZE PAYMENT OF BENEFITS TO THE PHYSICIAN OR PROVIDER DESCRIBED BELOW OR AS INDICATED ON THE ENCLOSED BILL. I UNDERSTAND THAT I AM FINACIALLY RESPONSIBLE TO THE PROVIDER FOR CHARGES IN EXCESS OF THE PLAN'S PAYMENT SCHEDULE OR CHARGES NOT COVERED BY MY BENEFIT PLAN.

SIGNED (SUBSCRIBER) DATE

OR

PAYMENT WILL BE MADE DIRECTLY TO YOU, IF YOU SIGN BELOW.

I AUTHORIZE REIMBURSEMENT OF BENEFITS TO MYSELF FOR SERVICES DESCRIBED BELOW 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.

SIGNED (SUBSCRIBER) DATE

PLEASE NOTE: PAYMENT FOR SERVICES RENDERED BY CONTRACTED/IN-NETWORK PROVIDERS WILL BE MADE TO THE PHYSICIAN OR PROVIDER OF SERVICE.

TO THE HOSPITAL – ATTACH FULLY COMPLETED UB-92 BILLING FORM.
OR
ATTACH FULLY ITEMIZED STATEMENT OF CHARGES AND CREDITS.

PHYSICIAN'S/SURGEON'S STATEMENT – COMPLETE FOLLOWING OR ATTACH FULLY COMPLETED HCFA 1500 FORM

PATIENT'S NAME: FIRST	INITIAL	LAST	DATE OF BIRTH

DATE OF	ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (LMP)	DATE FIRST CONSULTED YOU FOR THIS CONDITION	HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS? ☐ YES ☐ NO
DATE PATIENT ABLE TO RETURN TO WORK	DATES OF TOTAL DISABILITY FROM / THROUGH		DATES OF PARTIAL DISABILITY FROM / THROUGH
NAME OF REFERRING PHYSICIAN OR OTHER SOUCE (*e.g. public health agency)*			FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES ADMITTED / DISCHARGED
NAME & ADDRESS OF FACILITY WHERE SERVICES RENDERED (*if other than home or office)*			WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE? ☐ NO ☐ YES ▶ CHARGES

DIAGNOSIS AND CONCURRENT CONDITIONS			
PRIMARY	ICD10-CM CODE	SECONDARY	ICD10-CM CODE

PLACE OF SERVICE (POS)
- 1 – Inpatient Hospital
- 2 – Outpatient Hospital
- 3 – Doctor's Office
- 4 – Patient's Home
- 5 – Day Care Facility
- 6 – Night Care Facility
- 7 – Nursing Home
- 8 – Skilled Nursing Facility
- 9 – Ambulance
- 10 – Other Locations
- 11 – Independent Laboratory
- 12 – Other Medical/Surgical Facility
- 13 – Hospital Emergency Room

SERVICES RENDERED FROM	TO	No. OF SVCS.	POS.	DESCRIBE EACH SERVICE SEPARATELY	PROCEDURE NUMBER	AMOUNT BILLED	DO NOT USE THESE SPACES A	AA	O	R

SIGNATURE OF PHYSICIAN OR SUPPLIER	YOUR SOCIAL SECURITY NO.	TOTAL CHARGE	AMOUNT PAID	BALANCE DUE
SIGNED _____ DATE _____				
YOUR PATIENT'S ACCOUNT NO.	YOUR EMPLOYER I.D. NO.	PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE & TELEPHONE NO. I.D. NO.		

AUTHORIZATIONS TO ASSIGN BENEFITS WILL NOT BE HONORED UNLESS YOUR TAX IDENTIFICATION OR SOCIAL SECURITY NUMBER IS SHOWN.

*PLACE OF SERVICE CODES
1 – (IH) – INPATIENT HOSPITAL
2 – (OH) – OUTPATIENT HOSPITAL
3 – (O) – DOCTOR'S OFFICE
4 – (H) – PATIENT'S HOME
5 – DAY CARE FACILITY (PSY)
6 – NIGHT CARE FACILTY (PSY)
7 – (NH) – NURSING HOME
8 – (SNF) – SKILLED NURSING FACILITY
9 – AMBULANCE
O – (OL) – OTHER LOCATIONS
A – (IL) – INDEPENDENT LABORATORY
B – OTHER MEDICAL/SURGICAL FACILITY

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.