Request for Payment of Medical Services

Request for payment to:

❑ Doctor or provider ❑ Subscriber (Proof of payment must be included; see reverse.)

MEMBER INFORMATION			
First name Middle initial Last name			Date of birth MM/DD/YYYY
Member ID number	Home telephone ( )	Work telephone ( )	Sex ❑ Female ❑ Male

PHYSICIAN OR PROVIDER OF SERVICE INFORMATION	
Provider or facility where services received	NPI and tax ID # of provider of service
Address of provider or facility where services received	
Name of referring physician (if applicable)	
Diagnosis	

Date of service MM/DD/YYYY	Provider of service	**Charge**	**Amt. paid**
Description of service			

FOR PRESCRIPTION REIMBURSEMENT ONLY (See your prescription label for details.)				
Date filled MM/DD/YYYY		Days supply	**Charge**	**Amt. paid**
Rx number	Quantity	NDC number		
Prescribing physician name				
Pharmacy name and address			**Total**	**Total**

OTHER INSURANCE

Are you covered by other insurance (other than Medicare and/or Medicaid)? ❑ Y ❑ N

If yes, number: _____

Name and address of carrier: _____

Is the claim due to:

- an automobile accident? ❑ Y ❑ N Please explain: _____
- any other type of accident? ❑ Y ❑ N Please explain: _____
- the result of an occupational illness/injury? ❑ Y ❑ N

Comments: _____

AUTHORIZATION RELEASE

I, the undersigned, hereby authorize any physician, hospital, insurer, or other organization or person having any medical or other records, data or information concerning me or my minor dependent to furnish such records, data or information to Fallon Health. I understand that in executing this authorization, I waive all claim and right of privilege with regard to such information. A photocopy of this authorization shall be considered as effective and valid as the original bearing my signature.

Member/Authorized representative signature _____ Date _____

See reverse for instructions.

Instructions for submitting your Request for Payment of Medical Services

Follow these easy steps:

1. **Check** the appropriate box showing that you want payment sent to the doctor or to you. If you want payment to go directly to you, **attach some proof of payment such as a canceled check or paid receipt.** Remember to make a copy for your records.
2. **Complete** the "Member Information" section showing your name, member ID number and other identifying information.
3. **Complete** the "Physician or Provider of Service Information" section. Attach copies of itemized bills from the doctor or other provider. **Your request cannot be processed without the provider's NPI and tax ID number.** If this information is not on your receipt, please call the provider for this information.
4. **For prescription reimbursement only:** Complete the applicable section and attach your pharmacy receipt and label from your prescription bag to the form. If you no longer have this information, please contact the pharmacy and they can provide you with a printout.
5. **Complete** the "Other Insurance" section providing all information on other health insurance, automobile accident, other accident or occupational illness/injury (workers' compensation). Please do not include Medicare and/or Medicaid coverage.
6. **Sign and date** the Authorization Release.

With complete information, payment will be received within 4–6 weeks. We will contact you in writing if we need additional information regarding your claim.

After completing the form, please mail or email it with receipts to:

All medical claims:

Fallon Health
P.O. Box 211308
Eagan, MN 55121-2908

Email: reimbursements@fallonhealth.org

Pharmacy claims *(including covered Part D drugs, covered Part B drugs, diabetic glucose monitors, test strips and lancets)*:

Med D Paper Claims
P.O. Box 52066
Phoenix, AZ 85072-2066

If you are requesting reimbursement for both a medical and pharmacy claim, please submit two different forms.

For questions:

Fallon Senior Plan™ members, please call Customer Service at 1-800-325-5669 (TRS 711).

NaviCare® members, please call Enrollee Services at 1-877-700-6996 (TRS 711).

We are open 8 a.m.–8 p.m., Monday–Friday. (Oct. 1–Feb. 14, seven days a week.)

To receive payment, forms must be submitted to us within 365 days of the date of service.

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