KAISER PERMANENTE®

MEDICAL CLAIM FORM

Please follow the instructions on the reverse side of this form

EMPLOYEE INFORMATION

Employee Name (Last, First, Middle Initial):	Group Policy Number:	Employee Social Security Number:

Employee's Home Address (Street, City, State, Zip Code):

Employee's Date of Birth:	Employee's Home Telephone Number: ( )	❑ Male ❑ Female	❑ Single ❑ Married	❑ Divorced ❑ Widowed	❑ Legally Separated

Name and Address of Employer:	Employee Occupation:

Do you have more than one employer? ❑ Yes ❑ No If YES, give name and address of other employer:

Is your spouse employed? ❑ Yes ❑ No If YES, give name and address of spouse's employer:

Are you entitled to reimbursement of all or part of these expenses through any other coverage which provides medical benefits or services? ❑Yes ❑ No If YES, please provide us with the name, address, policy number, and effective date of the other carrier.

PATIENT INFORMATION
(TO BE COMPLETED ONLY IF PATIENT IS OTHER THAN EMPLOYEE)

Patient's Name (Last, First, Middle Initial):	Date of Birth:	❑ Male ❑ Female	❑ Single ❑ Married

Patient's Home Address (Street, City, State, Zip Code):	Patient's Relationship to Employee: ❑ Self ❑ Spouse ❑ Child ❑ Other

If Full-Time Student, Give School Name and City:

CLAIM INFORMATION

Nature of Illness/Reason for Service:	Has SHPS been contracted for pre-certification? ❑ Yes ❑ No

Is this claim based on an accident? ❑ Yes ❑ No If YES, complete the following:

Date of accident:	Time: ❑ A.M. ❑ P.M.	Describe how, when, and where accident occurred: Was injury related to an auto accident? ❑ Yes ❑ No

Are any of the illnesses or injuries for which this claim is being made related to employment? ❑ Yes ❑ No	Is this claim for pre-admission testing? ❑ Yes ❑ No

AUTHORIZATION SIGNATURE FOR INFORMATION RELEASE

I hereby authorize any insurance company, organization, employer, hospital, physician, surgeon, or pharmacy to release any information requested by Kaiser Permanente Insurance Company. A photostatic copy of this authorization shall be considered as effective and valid as the original.

Patient's signature, if claim is for dependent other than minor child: ______________________________

Date: ____ / ____ / ____ Signature of Employee: ______________________________

If payment is to be made to the provider, please sign below:

I hereby authorize payment of benefits to any providers of services otherwise payable to me for services but not to exceed the maximum allowable charge for these services. I understand that I am financially responsible for any charges not covered by this authorization.

Date: ____ / ____ / ____ Signature of Employee: ______________________________

Any person who knowingly presents a 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.

MEDICAL CLAIM FORM

How to file your claim:

1. Answer all questions and sign the authorization for information release on the reverse side of this form.

2. Attach itemized bills.
IMPORTANT: Each bill must show (a) name of patient; (b) date each expense was incurred; and (c) nature of illness or injury.

3. Forward completed claim form and bills to the address listed below.

4. If you have any questions regarding your claim, please call **Customer Service at 1-800-382-4661.**

Important Mailing Information

Please mail all claims to:

Kaiser Permanente Claims Department
P.O. Box 373150
Denver, CO 80237-3150