Claim Reimbursement Request

Instructions for Completing this Form and Submitting Your Claim

Who should complete this form?

MVP Level Funded members who have paid for medical expenses out-of-pocket and are requesting reimbursement.

Submit the required documentation.

Submit a separate reimbursement request for each bill, and include itemized receipts from providers and copies of your proof of payment.

To ensure prompt processing of your claim, submit only original bills, keep copies for your records. Bills submitted must include:

- The name and address of the provider (on letterhead) of the service or supply (e.g., doctor or hospital), including the Tax ID and NPI Numbers
- The patient's full name and health plan identification number
- HCPCS or CPT Code(s) for the type of service provided (e.g., office visit, chest x-ray)
- Place of service (e.g., inpatient or outpatient hospital, office)
- Date and charge for each service or supply provided
- ICD-CM code for the medical condition for which the patient was treated (e.g., routine exam, cough, hypertension)

Cash register receipts, canceled checks, money orders, credit card vouchers, or personal lists of services or bills stating only "balance forward" **are not acceptable as substitutes for original bills**.

If another insurance carrier has made payment on this service, an explanation of benefits from that carrier must be submitted with the claim.

Following these instructions and completing the claim form in its entirety will help us process your claim in a timely manner. Claims submitted without complete documentation cannot be processed and will be returned to you.

How to submit your completed claim.

Submit your completed claim and all documentation by:

- **Mail** to CLAIMS SUBMISSION, MVP HEALTH CARE, PO BOX 2207, SCHENECTADY NY 12301-2207
- **Email** to **submitclaims@mvphealthcare.com**
- **Fax** to **518-395-1395**

Questions? We're here to help!

Contact Health Plans, Inc. (HPI) Customer Service at **844-260-9900** or visit **mvphealthcare.com/MVPlevelfunding**.

Health Plans, Inc. (HPI) is a third party administrator (TPA) of self-funded health and benefit plans. To ensure you experience the best possible service, MVP has partnered with HPI, a Harvard Pilgrim company, to deliver and administer your plan.

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Section 1: Member and Patient Information *(please print)*

Patient Name *(first, middle initial, last)*

Patient Date of Birth

Subscriber Name *(first, middle initial, last)*

Member ID No.

Phone No.

Subscriber Street Address

City

State

Zip

Group Name

Group No. *(if applicable)*

Section 2: Provider and Billing Information

Provider Name

Phone No.

Date of Service

Provider Street Address

City

State

Zip

Tax ID No.

NPI No.

Total Reimbursement Requested ▶ $

Are you covered under another insurance plan that provides coverage for the type of service being submitted? ☐ **Yes** ☐ **No**

If ***Yes***, provide the following information about the insurance:

Insurance Company Name

Policyholder Name

Policy or ID No.

Other Carrier Phone No.

Policy/Other Carrier Effective Date

Insurance Company Street Address

City

State

Zip

Section 3: Certification and Authorization to Release

By signing below, I certify that the above statements are correct. I understand that any person who knowingly and with intent to defraud any insurance company or other person, files an application or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and shall be subject to a civil penalty not to exceed $5,000 and the stated value of the claim for each such violation.

Subscriber's Signature ***Date***

Assignment. I hereby authorize payment to the hospital or physician herein named. I understand I am financially responsible for charges not covered by this assignment.

Subscriber's Signature ***Date***

Authorization to Release. I hereby authorize Health Plans, Inc. or MVP Health Care® to release or obtain any information which may be necessary to administer this Group Plan. A photocopy of this authorization shall be valid.

Subscriber's Signature ***Date*** ***Patient's Signature**** ***Date***

**Parent should sign for a minor child.*