

# Medical Services Claim Form



Use this form to submit a claim for service(s) covered under your health plan, if an out-of-network provider can't submit a claim on your behalf. Complete all sections of this form, and attach the required documentation of your expenses. See the "How to Complete the Medical Services Claim Form" section to successfully submit your claim. Please use one form per medical claim.

If you have questions, contact Member Services at the number listed on your member ID card (TTY: **711**).

Note: liability for your claim will be determined based on your plan and the information you submit.

This is a foreign claim submission

<b>A Subscriber Information</b> - See "How to Complete the Medical Service Claim Form" section for instructions			
Last Name:	First Name:	Middle Initial:	Date of Birth (MM/DD/YYYY):
Member ID Number:		Group/Policy Number:	
Street Address:	City:	State:	ZIP Code:

<b>B Patient Information</b>			
Last Name:	First Name:	Middle Initial:	Date of Birth (MM/DD/YYYY):
Relationship to Subscriber:		Gender: <input type="radio"/> Male <input type="radio"/> Female	
Street Address:	City:	State:	ZIP Code:

<b>C Other Insurance Information</b>	
Is the patient covered by another health plan? <input type="radio"/> Yes <input type="radio"/> No If Yes, please complete the following and provide the Explanation of Benefits (EOB) from the other health plan company. If you don't have an EOB, please submit your claim to the other health plan company first.	
Name of Person Carrying Other Insurance:	Date of Birth (MM/DD/YYYY):
Employer Name if Applicable:	Member ID Number:

<b>D Claim Information</b>					
<b>Reason for Treatment (i.e. Illness/injury):</b>					
Place of Service:					
<input type="radio"/> Office <input type="radio"/> Hospital - Outpatient <input type="radio"/> Urgent Care <input type="radio"/> Emergency Room <input type="radio"/> Home <input type="radio"/> Other _____					
<input type="radio"/> Hospital - Inpatient: Date of Admission _____ Date of Discharge: _____					
Date(s) of Service (MM/DD/YYYY):	Diagnosis Code(s):	Service Code(s):	Modifier:	UOS / MOS:	Billed Amount \$:
Member Paid Amount (US \$):					
\$					

<b>E Provider Information</b>	
Facility / Billing Provider Information	
Name:	
Provider Street Address:	City: State: ZIP Code:
Provider Federal Tax Identification Number (TIN):	National Provider Identifier (NPI):
Physician / Servicing Provider Information	
Name:	
Provider Street Address:	City: State: ZIP Code:
National Provider Identifier (NPI):	

<b>F Foreign Claim Travel Information</b> (Complete only if services were received outside of the US or US territories)			
Date You Left U.S.A. (MM/DD/YYYY):	Intended Duration of Trip:	U.S. Departure Airport/Cruise Port:	U.S. Return Airport/Cruise Port:
Purpose of Trip:			
Description of Foreign Address at Time of Medical Treatment: <input type="radio"/> Hotel <input type="radio"/> Resort <input type="radio"/> Other _____			
Name of Hotel or Resort:			
Street Address:	City:	State:	ZIP Code:
Did you seek treatment due to an emergency? <input type="radio"/> Yes <input type="radio"/> No			
Consider your visit an emergency if your condition required immediate treatment [generally provided at the onset of a condition] to: <ul style="list-style-type: none"> <li>• Preserve your life</li> <li>• Prevent serious impairment to your bodily functions, organs, or parts</li> <li>• Prevent placing your physical or mental health in serious jeopardy</li> </ul> <b>Note:</b> Scheduled visits as well as follow up visits are not considered an emergency.			
What prompted you to seek medical care?			
Please provide details of accident or illness			
Name and address of witnesses			
Date of accident or illness began			

I certify that all information provided on this claim form is accurate to the best of my knowledge. I also certify, the patient for whom this claim is made, is insured under the plan and the service(s) is for the sole use of the named patient. I request any payment that may be made be issued directly to me. I also certify, to the best of my knowledge, the expenses I am submitting meet the requirements of qualified expenses as covered by my plan. I further certify that these expenses are not reimbursable under any other plan and have not been reimbursed by any other plan.

**Authorization:** On behalf of myself and any patient named on this claim form (“Us”), I authorize any health care professional or entity, employer, union, insurance company, health maintenance organization, other health plan company or prepayment organization to give Medica Health Plan Solutions and my employer, or any of their designees, any and all records or information pertaining to medical history or services rendered to Us for evaluation of this claim, and for any analytical or research purposes. This authorization will automatically expire one year from the date of signature unless I revoke it sooner.

A person who files a claim with the intent to defraud or helps commit fraud against an insurer is guilty of a crime.

Please check to see that this form has been properly completed and signed before submitting for reimbursement.

<b>G SIGNATURE</b>				
<table border="1" style="width: 100%;"> <tr> <td style="width: 50%;">Subscriber Signature:</td> <td style="width: 50%;">Date:</td> </tr> <tr> <td style="height: 40px;"></td> <td style="height: 40px;"></td> </tr> </table>	Subscriber Signature:	Date:		
Subscriber Signature:	Date:			

<b>H REQUIRED DOCUMENTATION</b>
<ul style="list-style-type: none"> <li><input type="radio"/> Proof of payment in full</li> <li><input type="radio"/> A provider bill on letterhead, itemizing the service(s) you received, including, but are not limited to, the date of service, place of service, procedure and diagnosis code(s), and charge amount by line.</li> <li><input type="radio"/> Other insurance - if you selected “YES” provide the Explanation of Benefits from the other insurance carrier.</li> <li><input type="radio"/> Foreign Claim: submissions must also provide proof of travel</li> <li><input type="radio"/> Foreign Claim: submissions must also provide medical records</li> <li><b>Note:</b> ALL Foreign Claim documentation must be translated to English</li> <li><input type="radio"/> Total number of pages attached: _____</li> </ul>

Mail your completed and signed Medical Services Claim Form and required documentation to the address below.

Medica  
 PO Box 211404  
 Eagan, MN 55121

If you have any questions or need assistance completing the form, please call Member Services at **1 (877) 357-3173** (TTY: **711**).  
 Monday - Friday 8 a.m. - 6 p.m. CT. Closed Thursdays 8 a.m. - 9 a.m. for training.

Member Services at the number on the back of your Medica ID card.

# How to Complete the Medical Services Claim Form



**Section A – Subscriber Information:** Please complete this entire section. The subscriber is the person who holds the medical plan coverage. The member ID number is shown on the front of the medical plan membership card.

**Section B – Patient Information:** Please complete this entire section. The patient is the member who received the medical services for which you are requesting reimbursement.

**Section C – Other Insurance Information:** Provide the information if you have other health care coverage under another plan.

**Section D – Claim Information:** Please complete this entire section for the medical expenses for which you would like considered. If you have questions about the information needed to complete this section, please contact your health care provider's billing department for assistance. They will be able to assist you with the information you need.

- **Place of Service:** Check a box to indicate whether you received the service at a doctor's office, a hospital as outpatient, an urgent care, an emergency room, in the home, a hospital as inpatient including admit and discharge dates, or at another location.
- **Date of Service:** The date you received the medical services or made the purchase.
- **Diagnosis Code:** A code used to identify diseases, disorders, and other reasons for patient encounters. Must be in ICD or CM format. Multiple diagnosis codes may be submitted on a single claim. If using this form to submit a dental claim, you do not need to fill in the diagnosis code.
- **Service Code:** A code used to identify the procedure, service, or supply received from a medical provider.
- **Modifier:** A 2-digit code used in addition to the Service Code to indicate that a service, or supply was distinct or independent from other services performed on the same day.
- **UOS/MOS (Unit of Service / Minute of Service):** The number of medical visits or procedures, units of anesthesia time, oxygen volume, items or units of service, etc.
- **Billed Amount \$:** The dollar amount charged for medical services rendered for each service code.
- **Member Paid Amount (US \$):** The dollar amount you paid to the provider. This dollar amount must match the amount on your proof of payment.

**Section E – Provider Information:** Please complete this entire section.

**Facility/Billing Provider Information & Physician/Service Provider Information:** Supply the following information about the physician who provided the service and the facility which the service was provided at. If you have questions about the information required to complete this section, please contact your health care provider's billing department for assistance. They will be able to provide you with the information you need.

- **Provider Name:** Complete legal name of institution, corporate entity, practice or individual provider.
- **Provider Address:** The number, street, city, state and ZIP code where the provider is located.
- **Provider Federal Tax Identification number (TIN):** A Federal Tax Identification Number, also known as an Employer Identification Number (EIN), used to identify a business entity, in the United States.
- **National Provider Identifier (NPI):** The NPI is a unique, 10-digit identification number given to health care providers and facilities, in the United States. The facility NPI and the physician NPI will be different numbers.

**Section F – Foreign Claim Travel Information:** Provide your travel schedule, reason for traveling, where you stayed, and details regarding the reason for seeking medical treatment.

- **Date You Left U.S.A.:** The date you left the United States.
- **Intended Duration of Trip:** How long you planned to travel.
- **U.S. Departure Airport or Cruise Port:** Provide the name of the airport or cruise port where you departed the United States.
- **U.S. Return Airport or Cruise Port:** Provide the name of the airport or cruise port where you returned to the United States.
- **Purpose of Trip:** Reason for traveling outside of the United States.

- Name of Hotel, Resort, or Description of Foreign Address at Time of Hospital Confinement: Where you stayed or who you visited and the address.
- Did You Seek Treatment Due To An Emergency? Indicate if the reason for seeking medical treatment was due to an emergent event.
- What Prompted You To Seek Medical Care? Provide detail as to what initiated you to seek medical care.
- Please Provide Details of Accident or Illness: Provide the detail of your reason for seeking medical care.
- Name and Address of Witnesses: Provide contact information for witnesses of your accident/illness.
- Date of Accident or Illness Began: Provide the date your accident occurred, or the date your illness first began.

**Section G – Signature:** Review the legal language, then sign and date the medical services claim form.

**Section H – Required Documentation:** When submitting this medical services claim form, you must include:

- Proof of Payment in Full: Documentation showing your payment to the provider for the total amount billed, for example: a canceled check or receipt from a credit card or cash payment receipt.
- Itemized Provider Bill: A provider bill on letterhead, itemizing the service(s) you received, which include, but are not limited to, the date of service, place of service, procedure and diagnosis code(s), charge amount by line.
- Foreign Claim Submissions – Proof of Travel: Documentation showing your date(s) and location(s) of travel, for example: airline ticket receipt, boarding pass, itinerary, hotel bill, or travel visa.
- Total Number of Pages Attached: Indicate how many pages of documentation you are attaching to the Medical Services Claim Form.

Proof of payment in full and an itemized statement can be obtained from your billing provider. Balance due statements are not acceptable proof of payment. Without the required documentation, your expense cannot be considered for processing. Documentation submitted with your claim will not be returned.

Your claim must be submitted within 365 days from the date of services being performed.

## Discrimination is Against the Law

Medica complies with applicable Federal civil rights laws and will not discriminate against any person on the basis of race, color, national origin, age, disability or sex. Medica:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as: TTY communication 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 and information written in other languages.

If you need these services, call the number included in this document or on the back of your Medica ID card. If you believe that Medica 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 Coordinator, Mail Route CP250, PO Box 9310, Minneapolis, MN 55443-9310, 952-992-3422 (phone/fax), TTY 711, [civilrightscoordinator@medica.com](mailto:civilrightscoordinator@medica.com).

You can file a grievance in person or by mail, fax, or email. You may also contact the Civil Rights Coordinator if you need assistance with filing a complaint.

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 (TDD). Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

### If you want free help translating this information, call the number included in this document or on the back of your Medica ID card.

Si desea asistencia gratuita para traducir esta información, llame al número que figura en este documento o en la parte posterior de su tarjeta de identificación de Medica.

Yog koj xav tau kev pab dawb kom txhais daim ntawv no, hu rau tus xov tooj nyob hauv daim ntawv no los yog nyob nraum qab ntawm koj daim npav Medica ID.

如果您需要免費翻譯此資訊，請致電本文檔中或者在您的 Medica ID卡背面包含的號碼。

Nếu quý vị muốn trợ giúp dịch thông tin này miễn phí, hãy gọi vào số có trong tài liệu này hoặc ở mặt sau thẻ ID Medica của quý vị.

Odeeffannoo kana gargaarsa tolaan akka isinii hiikamu yoo barbaaddan, lakkoobsa barruu kana keessatti argamu ykn ka dugda kaardii Waraqa Eenyummaa Medica irra jiruun bilbila'a.

إذا كنت تريد مساعدة مجانية في ترجمة هذه المعلومات، فاتصل على الرقم الوارد في هذه الوثيقة أو على ظهر بطاقة تعريف ميديكا الخاصة بك.

Если Вы хотите получить бесплатную помощь в переводе этой информации, позвоните по номеру телефона, указанному в данном документе и на обратной стороне Вашей идентификационной карты Medica.

ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປຂໍ້ມູນນີ້ຟຣີ, ໃຫ້ໂທຫາເລກໝາຍທີ່ມີຢູ່ໃນເອກະສານນີ້ ຫຼື ຢູ່ດ້ານຫຼັງຂອງບັດ Medica ຂອງທ່ານ.

이 정보를 번역하는 데 무료로 도움을 받고 싶으시면, 이 문서에 포함된 전화번호나 Medica ID 카드 뒷면의 전화번호로 전화하십시오.

Si vous voulez une assistance gratuite pour traduire ces informations, appelez le numéro indiqué dans ce document ou au dos de votre carte d'identification Medica.

နမူနာအား တာၤကွဲးထံၤစၢၤကလိၤန့ၢ်တၢ်ဂၢၢ်တၢ်ကၠိၤအံၤလၢအကလိၤန့ၢ်, ကိၤလိၤဝဲၤစီၤနီၢ်ဂီၢ်လၢအပုၤယုၢ်လၢလံၢ်တီၢ်မိၤအပုၤအံၤမ့တၢ်မ့ၢ်ဖဲန့ၢ်န့ၢ်ငၢၤလၢအလီၤခဲတၢ်ကၠၢၢ်အိၣ်န့ၢ်တၢ်ကၠၢၢ်.

Kung nais mo ng libreng tulong sa pagsasalin ng impormasyong ito, tawagan ang numero na kasama sa dokumentong ito o sa likod ng iyong Kard ng Medica ID.

ይህን መረጃ ለመተርጎም ነጻ እርዳታ የሚፈልጉ ከሆነ በዝህ ሰነድ ውስጥ ያለውን ቁጥር ወይም Medica መታወቂያ ኮድዎ በስተጀርባ ያለውን ይደውሉ።

Ako želite besplatnu pomoć za prijevod ovih informacija, nazovite broj naveden u ovom dokumentu ili na poleđini svoje ID kartice Medica.

Díí t'áá jíík'e shá ata' hodoonih nínízingo éí ninaaltsoos Medica bee néího'dílzinígí bine'déé' námboo biká'ígíjii' béésh bee hodílnih.

Wenn Sie bei der Übersetzung dieser Informationen kostenlose Hilfe in Anspruch nehmen möchten, rufen Sie bitte die in diesem Dokument oder auf der Rückseite Ihrer Medica-ID-Karte angegebene Nummer an.

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