

# Medical & Prescription Drug Claim(s) Form For Member Reimbursement



Please follow instructions carefully. Reimbursement requests that are missing needed information may be returned to you. Reimbursement requests will be processed within 45 days of receipt.

If payment is due, payments will be mailed to the mailing address on file.

1. Please use a separate claim(s) form for each patient and each provider of service.
2. Itemized receipts and **proof of payment** must be submitted along with this form.  
**All substantiating documentation must be legible.**
3. Explanation of Benefits from primary insurance must be submitted along with this form.

## Patient Information (who received medical care/services?):

Patient Name: \_\_\_\_\_ ID #: \_\_\_\_\_ Date of Birth \_\_\_\_\_

What is the patient's relationship to the subscriber?  Self  Spouse  Child  Other

## Subscriber Information: (Must be completed)

Subscriber Name: \_\_\_\_\_ ID #: \_\_\_\_\_

**Custodial Parent Information:** For reimbursement requests of a parent of a child when the requesting parent (a) is not enrolled in the same Group Health plan as the child, and (b) does not reside in the same household as the subscriber under the child's Group health plan.

Legal Custodian's Name: \_\_\_\_\_

Contact Phone Number: (\_\_\_\_) \_\_\_\_\_

Name and address payment is to be mailed to, if legal custodian and not the plan subscriber:

\_\_\_\_\_  
\_\_\_\_\_

If your child is covered under two or more health plans, state law determines the order benefits for processing claims.

Contact Name: \_\_\_\_\_ Contact Phone Number: (\_\_\_\_) \_\_\_\_\_

Address payment is to be mailed to: \_\_\_\_\_

\_\_\_\_\_

## Medical/Vision Service Information:

Must be completed or attach a legible provider's itemized statement of services received.

Date of service: \_\_\_\_\_ Provider name: \_\_\_\_\_

Address: \_\_\_\_\_

Tax identification number: \_\_\_\_\_

Condition or diagnosis: \_\_\_\_\_

Service codes or description of services: \_\_\_\_\_

Charges for each line: \_\_\_\_\_

Explanation of Benefits if primary insurance has paid/denied: \_\_\_\_\_

\_\_\_\_\_

Have these charges been paid in full?  No  Yes *Please attach proof of payment*

**Complete applicable sections on page 2 and sign.**

**Other Insurance Information:**

Are you or any of your family members covered by another health plan?  No  Yes

If so

please include Subscriber Name: \_\_\_\_\_

Name of other insurance company: \_\_\_\_\_

Did your primary insurance make payment?  No  Yes. *Please attach Explanation of Benefits*

**For Pharmacy Charges:**

Please attach legible copies of receipts that include the following information: fill date, drug name, drug strength, quantity, days supply, prescription number and your cost.

**For Services Related to MVA, L&I, or PIP:**

Were services due to a motor vehicle accident, worker’s comp, or personal injury?  No  Yes

Date of accident: \_\_\_\_\_

**For Services Out of Country, please provide name of country:** \_\_\_\_\_

Were services rendered at:

Office/Clinic  Emergency Room  Urgent Care

Pharmacy  Inpatient/Outpatient Hospital

Please explain injury or illness: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please submit all itemized receipts, proof of payment and Explanation of Benefits along with the claim(s) form to:

**Claims Processing  
Group Health Cooperative  
PO Box 34585  
Seattle, WA 98124-1585**

If you have any questions, please contact Customer Service toll-free at 1-888-901-4636 (TTY Relay: 711 or 1-800-833-6388). You can also go to [www.ghc.org](http://www.ghc.org), click on “Customer Service” and send us an e-mail.

It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_