Request for Payment of Medical Services

Request for payment to:

❑ Doctor or provider

❑ Subscriber ❑ Member (Proof of payment must be included for subscriber or member; see reverse.)

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

PHYSICIAN OR PROVIDER OF SERVICE INFORMATION	
Provider or facility where services received	NPI or tax ID number 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			

INTERNATIONAL SERVICE INFORMATION (Complete if service was outside the U.S.)	
Country where services were rendered	Language of documentation
Currency paid	How was payment made? (i.e.: check, credit card, cash)

OTHER INSURANCE

Is member covered by other insurance? ❑ Y ❑ N If yes, number: _____

If yes, 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: _____

an occupational injury or illness? ❑ Y ❑ N

Comments: _____

SUBSCRIBER INFORMATION ❑ Check if same as above.	
Subscriber's name	
Subscriber's address	
City, State, ZIP	
Home telephone ( )	Work telephone ( )

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.

Subscriber signature _____ Date _____

Patient signature _____ Date _____
(if other than insured or minor)

(over)

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 provider or to you. If you want payment to go directly to you, **attach some proof of payment such as a canceled check (front and back)** or **dated original receipt(s) from your provider showing you have a zero balance, or a copy of your bank/credit card statement showing you paid.**

   For international claims: If you paid cash, please include a copy of the source of the cash such as proof of wire transfer, traveler check receipt, or your bank statement. All documentation must be in English.

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/ tax ID number.** If this information is not on your receipt, please call the provider for this information.

4. **Complete** the "Other Insurance" section providing all information on other health insurance (if applicable), automobile accident, other accident, or occupational illness/injury (workers' compensation).

5. **Sign and date** the Authorization Release.

Once all required information is received, you will receive your payment within 4-6 weeks. We'll contact you in writing if we need more information.

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

Fallon Health
P.O. Box 211308
Eagan, MN 55121-2908
Email: reimbursements@fallonhealth.org

If you have any questions, please call Customer Service at 1-800-868-5200 (TRS 711). We're here Monday, Tuesday, Thursday, and Friday, 8 a.m.–6 p.m., and Wednesday, 10 a.m.–6 p.m.

To receive payment, forms must be submitted within one year of the date of service.

fallonhealth