Kaiser Foundation Health Plan, Inc.
California

CLAIM FOR EMERGENCY MEDICAL SERVICES

For complete information about your emergency benefits or applicable copayments, deductibles, or coinsurance that are your responsibility, please refer to your Evidence of Coverage booklet.

Note: If your primary health coverage is through another medical plan, you must file your claim with that plan first. If there is a balance remaining after your primary medical plan decides your claim, you may file a claim for Kaiser Foundation Health Plan to pay the difference. Complete the attached Claim for Payment of Emergency Medical Services form and mail it along with a copy of your other plan’s Explanation of Benefits. Also attach a copy of all related itemized bills. Please refer to your Evidence of Coverage for additional information.

Instructions
To request reimbursement for emergency services received at a non–Kaiser Permanente facility:
1. Complete both sides of the attached Claim for Payment of Emergency Medical Services form.
2. Attach all applicable additional information that is requested on the back of the claim form.
3. Date and sign the form.
4. Detach and keep this instruction sheet and make a copy of the Claim for Payment of Emergency Medical Services form for your records.
5. Mail your completed form, along with any itemized bills, to one of the following addresses:

For Southern California Members: Kaiser Foundation Health Plan, Inc.
Claims Department
P.O. Box 7004
Downey, CA 90242-7004

For Northern California Members: Kaiser Foundation Health Plan, Inc.
Claims Department
P.O. Box 12923
Oakland, CA 94604-2923

We will process your claim upon receipt of this completed form. If we need additional information, we will notify you. For information about our time frames for processing your claim, please refer to your Evidence of Coverage.

If you have any questions or need assistance, please call our claim services at 1-800-390-3510.
Kaiser Foundation Health Plan, Inc.
California Division

CLAIM FOR EMERGENCY MEDICAL SERVICES

IN ORDER FOR YOUR CLAIM TO BE CONSIDERED FOR PAYMENT:
• BOTH SIDES OF THIS FORM MUST BE COMPLETED IN FULL.
• ALL ITEMIZED BILLS FOR THIS EMERGENCY MUST BE ATTACHED.
• IN MOST CASES, PAYMENT WILL BE MADE TO PROVIDER(S) UNLESS PROOF
  OF PAYMENT IS FURNISHED BY THE MEMBER OR PROVIDER(S).

• FOREIGN CLAIM PAYMENTS WILL BE MADE TO THE MEMBER
  WHEN DOCUMENTED PROOF OF PAYMENT IS FURNISHED BY
  THE MEMBER, AND/OR POWER OF ATTORNEY, ESTATE OR
  FINANCIAL DESIGNEE, WHEN PROPERLY IDENTIFIED FOR
  DECEASED MEMBERS, IS PROVIDED.

PATIENT NAME
LAST                        FIRST                      INIT          SEX          BIRTH DATE

PATIENT ADDRESS             STREET                      CITY                      STATE          ZIP

SUBSCRIBER NAME             LAST                        FIRST                      INIT          RELATION TO PATIENT          PATIENT DAY TELEPHONE

SUBSCRIBER ADDRESS          STREET                      CITY                      STATE          ZIP

PLACE OF ILLNESS/INJURY     CITY                        STATE/COUNTRY              INCIDENT DATE          TIME

PLACE OF EMERGENCY CARE     CITY                        STATE/COUNTRY              TREATMENT DATE          TIME

IS PATIENT COVERED BY MEDICARE OR OTHER MEDICAL INSURANCE?

Yes  ☐ No

NAME OF POLICY HOLDER/SUBSCRIBER

IF YES, INSURANCE COMPANY NAME
ADDRESS
TELEPHONE
SUBSCRIBER ID NUMBER

INSURANCE COMPANY NAME
ADDRESS
TELEPHONE
SUBSCRIBER ID NUMBER

IS MEDICAL COVERAGE PART OF THE CAR INSURANCE POLICY?

Yes  ☐ No

NAME OF POLICY HOLDER

IF YES, AUTOMOBILE INSURANCE COMPANY NAME
ADDRESS
TELEPHONE
POLICY NUMBER

MEMBER’S DESCRIPTION OF HOW THE EMERGENCY OCCURRED

WHY WAS THE PATIENT NOT TREATED AT A KAISER PERMANENTE FACILITY?

I authorize __________________________________________________________ ____________________________
(names of providers) to release any and all information, including medical and/or hospital records pertaining to the health care services provided to me on/between the dates listed on this Claim
for Emergency Medical Services. I understand that this information is necessary to allow Kaiser Foundation Health Plan, Inc., to
process my claim for payment of these services.

AUTHORIZING SIGNATURE: PARENT’S SIGNATURE IF PATIENT IS A MINOR
DATE SIGNED

(For Spanish, use 60323113)

PLEASE COMPLETE THE REVERSE SIDE

60323211
CLAIM FOR EMERGENCY MEDICAL SERVICES (Continued)

WHEN DID YOU NOTIFY KAISER PERMANENTE?

WITH WHOM DID YOU SPEAK?

NAME OF YOUR KAISER PERMANENTE DOCTOR

AT WHICH KAISER PERMANENTE MEDICAL OFFICE DO YOU RECEIVE YOUR REGULAR CARE?

WAS THE INJURY OR ILLNESS WORK-RELATED?

☐ Yes ☐ No

IF YES, PLEASE ATTACH EXPLANATION OF PAYMENT OR DENIAL FROM THE WORKERS’ COMPENSATION CARRIER.

WAS THIS INJURY THE RESULT OF A MOTOR VEHICLE ACCIDENT?

☐ Yes ☐ No

IF YES, PLEASE SEND A COPY OF THE AUTO POLICY FACESHEET FOR THE VEHICLE IN WHICH THE PATIENT WAS RIDING. PLEASE SPECIFY WHETHER THE PATIENT WAS THE DRIVER OR PASSENGER.

WAS THIS INJURY CAUSED BY SOMEONE ELSE?

☐ Yes ☐ No

IF YES, NAME OF PARTY AGAINST WHOM YOU HAVE A CLAIM

PARTY’S INSURANCE COMPANY NAME AND ADDRESS

Policy Number

If you have retained an attorney, please give the attorney’s name, address, and phone number

ATTORNEY’S NAME

ADDRESS

TELEPHONE

Please be sure to include the following information to help expedite the claim.

Attach all applicable additional information that is requested on this form and make a copy of that information for your records.

Please make sure to include your name and medical record number on each document and submit the following information: documentation of power of attorney, estate or financial designee for deceased members, if applicable, so that we may process your claim.

The following information is required for all claims:

• Itemized bills
• Medical records and/or reports that you may have in your possession or to which you have access to receipts of payment
• Medical record number (that matches the medical record number on your Kaiser Permanente ID card)

Foreign claim reimbursement requirements:

1. Proof of payment: receipt or bank statement, copies of original checks (front and back)
2. Proof of pharmaceutical payment: include with claim form and provide copies
3. Proof of travel: travel documentation, for example, copy of travel itinerary and/or airline tickets
4. Diagnosis noted on claim form
5. Copies of original itemized bills of service—professional, hospital, and pharmaceutical
6. Applicable supporting medical records: copies of original medical report, admission notes, emergency room records, and consultation report—if possible, translated in English prior to submission

(MR#: ____________________________
Name: ____________________________

Required

FOR SPANISH, USE 60323113)