Medical Claim Form

KAISER PERMANENTE
Insurance Company

Please follow the instructions on the reverse side of this form

Employee Information

Employee Name (Last, First, Middle Initial)	Group Policy Number	Employee Social Security Number
		- -

Employee's Home Address (Street, City, State, Zip Code)

Employee's Date of Birth	Employee's Home Telephone Number ( )	❑ Male ❑ Female	❑ Single ❑ Married	❑ Divorced ❑ Widowed	❑ Legally Separated

Name and Address of Employer	Employee Occupation

Do you have more than one employer? ❑ Yes ❑ No If YES, give name and address of other employer:

Is your spouse employed? ❑ Yes ❑ No If YES, give name and address of spouse's employer:

Are you entitled to reimbursement of all or part of these expenses through any other coverage which provides medical benefits or services? ❑ Yes ❑ No If YES, please provide us with the name, address, policy number, and effective date of the other carrier.

Patient Information
(To be completed only if patient is other than employee)

Patient's Name (Last, First, Middle Initial)	Date of Birth	❑ Male ❑ Female	❑ Single ❑ Married

Patient's Home Address (Street, City, State, Zip Code)	Patient's Relationship to Employee ❑ Self ❑ Spouse ❑ Child ❑ Other

If Full-Time Student, Give School Name and City

Claim Information

Nature of Illness/Reason for Service	Has SHPS been contacted for precertification? □ Yes□ No

Is this claim based on an accident? ❑ Yes ❑ No If YES, complete the following:

Date of accident:	Time: ❑ a.m. ❑ p.m.	Describe how, when, and where accident occurred: Was injury related to an auto accident? ❑ Yes ❑ No

Are any of the illnesses or injuries for which this claim is being made related to employment? ❑ Yes ❑ No
Is this claim for pre-admission testing? ❑ Yes ❑ No

Authorization Signature for Information Release

I hereby authorize any insurance company, organization, employer, hospital, physician, surgeon, or pharmacy to release any information requested by Kaiser Permanente Insurance Company. A photostatic copy of this authorization shall be considered as effective and valid as the original.
Patient's signature, if claim is for dependent other than minor child:_____

Date:___ / ___ / ___ Signature of employee: _____

If payment is to be made to the provider, please sign below:
I hereby authorize payment of benefits to any providers of services otherwise payable to me for services but not to exceed the maximum allowable charge for these services. I understand that I am financially responsible for any charges not covered by this authorization.

Date:___ / ___ / ___ Signature of employee: _____

In Maryland and the District of Columbia, any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

How to file your claim:

1. Answer all questions and sign the "*Authorization signature for information release*" on the reverse side of this form.

2. Attached itemized bills – **important** – each bill must show (a) name of patient, (b) date each expense was incurred, and (c) nature of illness or injury.

3. Forward completed claim form and bills to the address listed below.

   Please note that PHCS providers are to submit your claims directly to KPIC. However, if this does not take place, you may do this yourself by submitting this medical claim form to the address below.

   Important mailing information
   Please mail all claims to:

   Kaiser Permanente Insurance Company
   P.O. Box 261130
   Plano, TX 75026