Prominence Health Plan

Member Claim Form

Prominence Health Plan
Claims Department
1510 Meadow Wood Lane
Reno, NV 89502

MEDICAL/DENTAL/VISION
SEE REVERSE SIDE FOR CLAIM FILING INSTRUCTIONS

1. SUBSCRIBER NUMBER	2. GROUP NUMBER	3. PATIENT NAME (Last, First, Initial) (PLEASE PRINT)	4. PATIENT BIRTHDATE MO / DAY / YR.

5. PATIENT SEX ☐ MALE ☐ FEMALE

6. PATIENT RELATIONSHIP TO SUBSCRIBER ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER

7. SUBSCRIBER NAME (Last, First, Initial)

8. SUBSCRIBER ADDRESS (Street, City, State, Zip Code)

COORDINATION OF BENEFITS INFORMATION

9. WERE THESE SERVICES REQUIRED AS A RESULT OF A JOB-RELATED ILLNESS OR ACCIDENT? ☐ YES ☐ NO
IF NO GO TO QUESTION 10

9a. NAME AND ADDRESS OF EMPLOYER

9c. DATE OF ACCIDENT

10. WERE SERVICES REQUIRED FOR A CONDITION RESULTING FROM AN ACCIDENT OR INJURY CAUSED BY ANOTHER PARTY? ☐ YES ☐ NO
IF NO GO TO QUESTION 11

10a. DATE OF ACCIDENT OR INJURY (MM/DD/YYYY)

11. ARE ANY FAMILY MEMBERS EXPENSES COVERED BY ANOTHER GROUP HEALTH PLAN OR ANY FEDERAL, STATE, OR LOCAL GOVERNMENT PLAN? ☐ YES ☐ NO

11a. NAME/ADDRESS OF INSURANCE COMPANY OR ADMINISTRATOR

11b. EMPLOYER NAME/GROUP NUMBER

11c. MEMBER'S ID NUMBER

11d. MEMBER'S NAME (LAST, FIRST, INITIAL)

11e. MEMBER'S BIRTHDATE (MM/DD/YYYY)

12. IS PATIENT ELIGIBLE FOR MEDICARE PART A AND/OR PART B
IF NO GO TO QUESTION 13
PART A ☐ YES ☐ NO
PART B ☐ YES ☐ NO

12a. MEDICARE NUMBER

MEDICAL/SERVICE INFORMATION

13. ILLNESS OR SYMPTOMS (DIAGNOSIS CODE FROM ITEMIZED STATEMENT) FOR REIMBURSEMENT

14. NAME OF PROVIDER WHO RENDERED THE SERVICE AND PHONE NUMBER
NAME PHONE NO.

16. IF WE HAVE QUESTIONS, WHO MAY WE CONTACT?
NAME PHONE NO.

15. IF PLACE OF SERVICE WAS OUTPATIENT OR INPATIENT HOSPITAL, PROVIDE NAME OF HOSPITAL FACILITY

PLEASE COMPLETE THE FOLLOWING AS A SUMMARY OF THE ITEMIZED BILLS YOU HAVE ATTACHED TO THIS CLAIM FORM

17. DATE OF SERVICE	18. PLACE OF SERVICE*	19. CHARGE FOR SERVICE	20. BRIEFLY DESCRIBE THE SERVICE(S) YOU RECEIVED

21. TOTAL CHARGES FOR WHICH YOU ARE REQUESTING CONSIDERATION OF PAYMENT? $ **$0.00**

* PLACE OF SERVICE
O - OFFICE
H - HOME
OP - OUTPATIENT HOSPITAL
NH - NURSING HOME
IP - INPATIENT HOSPITAL
P - PHARMACY
L - LAB

22. I CERTIFY TO THE ACCURACY AND COMPLETENESS OF ALL INFORMATION REPORTED BY ME ON THIS FORM AND AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM.

SIGNATURE DATE

FULL SIGNATURE AND DATE REQUIRED ON EACH FORM
INCOMPLETE FORMS MAY DELAY PROCESSING. PLEASE ENSURE ALL FIELDS ARE ANSWERED.

SUBSCRIBER CLAIM FILING INFORMATION (HOW TO FILE)

Be sure to ask your provider of care if he/she will file a claim with Prominence Health Plan. Please submit statements only if the provider does not bill us directly. To receive benefits for services by a provider who does not bill us directly, complete the Claim Form, attach itemized bills, proof of payment (if applicable) and mail to:

Prominence Health Plan
Claims Department
1510 Meadow Wood Lane
Reno, NV 89502

Keep a duplicate copy of your itemized bills and proof of payment as they will not be returned to you. **This claim may be returned to you if all required information is not present.**

CLAIM FILING INSTRUCTIONS

(Corresponds to numbered items on Claim Form)

A separate Claim Form for each family member and each provider of care must be submitted.

ITEM NO.

1–8	Please complete all blocks. All fields required.
9-12a	Appropriate responses to these questions will ensure expedient and proper handling of your claim.
13	Statement of why these services were required.
14	Indicate the name of the physician, hospital or other institutional facility who has billed for services provided to the patient. **Only one provider per form.**
15	If laboratory or radiology services are being billed by a professional provider, and the place of service was inpatient or outpatient hospital, indicate the name of the hospital.
16	Name and telephone number; whoever can help us if additional information is required.
17	Use a separate line for each date of service and receipt.
18	Write the appropriate code to indicate the place of service by using the legend below this section.
19	Indicate the total charge for each service.
20	Briefly indicate the type of service, i.e. lab, X-ray, surgery, therapy, cast, stitches, etc.
21	This amount represents the total of all charges to be considered for benefit.
22	Your signature attests to the accuracy and completeness of all information on the claim and the attachments and authorizes the release of your medical records by the provider to our office if necessary.

REQUIRED INFORMATION

Itemized Bills: Summarizing the services may help us better understand the attachments if they are not clear. The attached itemized bills must include the provider name, patient's name, date of service, detailed description of service, and amount charged for that service. These must be valid documents from the provider.

HELPFUL HINTS

- If you have questions or need assistance, contact Prominence Health Plan Customer Service at 800-863-7515 (HMO) or 800-433-3077 (PPO).
- To reduce the possibility of small billings getting lost or separated, please attach these to an 8 1/2x11 piece of paper.
- We encourage you to file claims within 90 days of the service date. Please refer to your Evidence of Coverage (EOC) (HMO) or Certificate of Coverage (COC) (PPO) for specific timely filing limitations.
- File only if the provider has not.

Important: If the services for this claim were provided by a participating physician or hospital, the benefit payment will go to the provider.

A complete description of your benefits, as well as limitations and exclusions applicable thereto, is available in the EOC and COC. Final interpretation of any and all provisions of the program is governed by the EOC and COC.