Harbor Health

Individual and Family Member Form

Select One	Type of Service	Description
◯	Emergency Services Out-of-Network/Outside the United States	Medical emergencies are services that are required to stabilize or begin treatment in an emergency. Emergency Health Care Services must be received on an outpatient basis at a hospital or alternate facility, independent freestanding emergency department, or comparable emergency facility.
◯	Other	Please refer to your Evidence of Coverage for Covered Health Services. Other than noted in your Evidence of Coverage, out-of-network non-emergency services will not be reimbursed without prior approval.

*See your Evidence of Coverage (EOC) and Schedule of Benefits for more information on Covered Health Services

Network providers will submit claim(s) on your behalf to Harbor Health for processing. Other than noted in your Evidence of Coverage, out-of-network non-emergency services will not be reimbursed without prior approval.

Return this form with a copy of the bill(s) and receipt (proof of payment) via mail. You must submit the claim no later than 95 days after the date of service. This time limit does not apply if you are legally incapacitated. If your claim relates to an inpatient stay, the date of service is the date your inpatient stay ends.

To ensure prompt processing of your claim, please do the following:

Use blue or black ink to complete this form and print clearly and legibly. Complete all of the applicable fields on the form. Ask your provider for the Provider information or have them complete the provider section. You need to submit a separate form for each claim.

If you have other insurance or Medicare and that other insurance is primary to your Harbor Health plan, please include the Explanation of Benefits (EOB) from your other insurance or Medicare.

Ask your provider for a bill/invoice that includes all of the following for each date of service:

- Patient Name
- Provider Tax ID# or NPI
- Diagnosis codes and description
- Procedure Codes with applicable modifiers and description
- Units for each procedure code
- The billed amount for each procedure code
- Place of service code

Claims may be delayed if all sections of this form are not completed. You will be notified should additional information be required.

What happens next:
After we process your claim, we will send you an Explanation of Benefits (EOB). The EOB will explain how your claim was processed. If applicable, you will also receive reimbursement for covered health services. Please keep your EOB on file for future reference.

Submission of this form does not guarantee reimbursement. Claims will be evaluated based on plan coverage and applicable limitations as outlined in the member's Evidence of Coverage.

Once you have completed the form, mail it to the address on the back of your ID Card. Be sure to attach the provider bill/invoice and any receipts (proof of payment).

Continued on next page

Harbor Health Medical Claim, cont.

NOTE: Please maintain a copy of this document for your records.

Member ID (from Health Plan ID card) ___ ___ ___ ___ ___ ___ ___ ___ ___-___ ___

Group Number ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

Patient Information

Name (Last, First, MI): DOB (mm/dd/yyyy): / /

Home Address: City: State: Zip:

New Address: ☐ Yes ☐ No Phone #: ( ) -

Gender: ☐ M ☐ F

Relationship to Subscriber: ☐ Subscriber ☐ Spouse/Partner ☐ Child ☐ Dependent

Subscriber Information *(Complete this section only if it is different than the patient information.)*

Subscriber Name (Last, First, MI): DOB (mm/dd/yyyy): / /

Home Address: City: State: Zip:

New Address: ☐ Yes ☐ No Phone #: ( ) -

Provider Information *(This information is required to process the claim. Ask your provider for this information or have them fill out.)*

Provider (or Rendering Provider) Name: Provider Tax Identification Number:

NPI Number: Group/Facility Name:

Provider Address: City: State: Zip:

Country: Phone #: ( ) -

Address Where Services Were Rendered: City: State: Zip:

Phone #: ( ) -

Type of Treatment (CPT Code and Description) *Use additional page if needed*	**Diagnosis/Description of Illness or Accident** *(ICD10 Code & Description)*	**Date of Service** *(mm/dd/yyyy)*	**Amount Billed**	**Currency** *(if other than US)*
		/ /		
		/ /		
		/ /		

Accident Information *(If applicable)*

Date of accident (mm/dd/yyyy): / /

Type of Accident: ☐ Work ☐ Auto ☐ Other

How did the accident happen?

Other Insurance *(If applicable)*

Is the patient covered by another insurance plan? ☐ Yes ☐ No (If yes, please complete the following information):

Name of Person Carrying Other Insurance (Last, First, MI):

DOB of person carrying other insurance (mm/dd/yyyy): / /

Name of Other Insurance Carrier: Policy Number: Employer Name:

Effective Date of Other Insurance: / / Cancellation date of Other Insurance (if applicable): / /

Did you attach an EOB from Medicare or your other insurance: ☐ Yes ☐ No

Submission of this form does not guarantee reimbursement. Claims will be evaluated based on plan coverage and applicable limitations as outlined in the member's Evidence of Coverage.

I authorize my provider to release medical information and records necessary to process this claim.
Signature (Patient Signature or Legal Representative) _____ Date: ____ / ____ / _____

By signing below, I am stating that the information above is correct. Any person who knowingly submits false, misleading, or incomplete information in connection with a claim for benefits may be committing a crime and could be subject to criminal penalties under applicable state or federal law.

Signature (Member/Legal Guardian): Name (Print): Date (mm/dd/yyyy):

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