KAISER PERMANENTE®

Member Reimbursement Form

Instructions:

- Fill out this form to request reimbursement for amounts you PAID the provider.
- If you have not paid the provider, DO NOT USE THIS FORM. Ask the provider to bill us directly using a CMS 1500 or UB-04 claim form.
- Make sure the provider has your Kaiser Permanente membership information.
- Fill out the form completely and sign it. Send all required documents. **Incomplete or unsigned forms will be returned to you.**
- If you are filling out the form on behalf of someone else, please attach either a Power of Attorney Form or Authorization of Representation Form. Parents do not need to submit these additional forms if signing on behalf of minor children or legal dependents.
- Keep a copy of this form and all documents for your records.
- For questions or help with this form, please call Member Services at the number listed below.

SECTION A: Patient information

Last name

First name MI

Patient address

City State ZIP

Mailing address ☐ Check if the same as the home address.

City State ZIP code

Date of birth (mm/dd/yyyy) / / Medical record number (found on ID card)

Is the patient covered under Medicare? ☐ Yes ☐ No Was the care received due to an auto accident? ☐ Yes ☐ No

Is the patient covered under Medicaid/Medi-Cal? ☐ Yes ☐ No Is this a prescription reimbursement request? ☐ Yes ☐ No

Is the patient covered under both Medicare and Medicaid/Medi-Cal? ☐ Yes ☐ No

Does the patient have other health coverage? ☐ Yes ☐ No If "Yes" complete Section B below.

SECTION B: Other coverage information

Name and address of other coverage carrier

Subscriber ID number	Group number
Employer name	Carrier telephone number

SECTION C: Explanation of treatment (optional)

Please describe the services you received. Explain why treatment was not done at Kaiser Permanente.

Was an ambulance used?

☐ Yes ☐ No

If "Yes," who called the ambulance?

☐ Patient ☐ Kaiser Permanente ☐ Police/Fire ☐ Other:

Was the patient admitted to the hospital?

☐ Yes ☐ No

If "Yes" – admit date (MM/DD/YYYY) ☐☐/☐☐/☐☐☐☐

If "Yes" – discharge date (MM/DD/YYYY) ☐☐/☐☐/☐☐☐☐

SECTION D: Required information for reimbursement

To prevent processing delays, you **MUST** provide the following information:

1. **Proof of payment:** We need proof you paid the provider. Send us your receipt, bank statement, copies of original checks (front and back), or any other documents showing how much you paid the provider; AND
2. **Provider's bill:** Send us a copy of the provider's bill you paid. Please include all pages and any detailed billing statements. Or, if you do not have a copy of the bill, please provide the following information:

Name of patient and medical record number	
Dates of service	
Name of provider (doctor, hospital, ambulance service, pharmacy, laboratory, etc.)	
Address where service was provided (hospital address, doctor address, etc.)	
Services provided to you (X-ray, office visit, injection, prescription, etc.).	
Amount billed	

Note: All documents and information submitted must be legible or the form will be returned.

SECTION E: Cruise or foreign travel reimbursement required documentation

Was the service provided during a cruise or foreign travel? ☐ Yes ☐ No; If "No" please skip. If "Yes", please provide the following information.

- ☐ Proof of travel: Travel documents; such as a copy of airline tickets or a travel itinerary (optional)
- ☐ Copies of original, detailed bills of service (doctor, hospital, and prescriptions)
- ☐ Any related medical records, including copies of medical reports, hospital admission notes, emergency room notes, etc.
- ☐ Proof of payment for services received, including prescriptions (receipt or bank statement, copies of front and back of checks, or any other documents showing how much you paid the provider)

Note: All documents and information submitted must be legible or the form will be returned.

Patient signature

I certify that the information provided on this form is correct to the best of my knowledge. I authorize the release of all information related to the health care services I received on the dates listed on this form. I understand that this information is necessary to allow Kaiser Foundation Health Plan, Inc., to process my claim for payment.

Patient/Authorizing name (parent's signature if patient is a minor or legal dependent)

Patient/Authorizing signature (parent's signature if patient is a minor or legal dependent)	Date signed

Best contact/telephone number

Reimbursement mailing addresses and Member Services phone numbers

COLORADO
Claim Address
P.O. Box 373150
Denver, CO 80237-9998
Member Services
1-303-338-3800

GEORGIA
Claim Address
P.O, Box 370010
Denver, CO 80237-9998
Member Services
1-888-865-5813

CALIFORNIA – SCAL
Claim Address
P.O. Box 7004
Downey, CA 90242-7004
Member Services
1-800-464-4000

MD, DC, OR VA
Claim Address
P.O. Box 371860
Denver, CO 80237-9998
Member Services
1-800-777-7902

HAWAII
Claim Address
P.O. Box 378021
Denver, CO 80237-9998
Member Services
1-800-966-5955

CALIFORNIA – NCAL
Claim Address
P.O. Box 12923
Oakland, CA 94604-2923
Member Services
1-800-464-4000

NORTHWEST
Claim Address
P.O. Box 370050
Denver, CO 80237-9998
Member Services
1-800-813-2000

KP WASHINGTON
KPWA Claims Administration
P.O. Box 30766
Salt Lake City, UT 84130-0766
Member Services
1-888-767-4670

SELF-FUNDED MEMBERS
KPIC Self-Funded Claims Administration
P.O. Box 30547
Salt Lake City, UT 84130-0547
Member Services
1-800-533-1833