HealthPlans
A HARVARD PILGRIM COMPANY

Supplemental Claim Filing/Reimbursement Form

Employer Name: _____ **Group Number:** _____

INSTRUCTIONS

Please complete the information below and attach any documentation (receipts, bills, etc.) describing the services that you or your covered dependent has received. Please be sure to include the provider's name and full address, the date(s) of service(s), a description of the service(s), the full amount of the charges, and the amount, if any, that you have already paid. Claims for different plan members must be on separate forms.

- **Please tape your receipts** to the back of this form, or to an additional sheet if necessary.
- **Please do not use staples or paperclips,** as these may cause a delay in processing.

Employee Last Name	*First Name*	*MI*	*Health Plans Member ID #*	*Date of Birth*

Mailing Address	*City*	*ST*	*ZIP Code*	*Daytime Phone#*	*Email Address*

Member/Dependent Information

Reimbursement is requested for the following plan member (please check): ☐ Employee ☐ Spouse ☐ Child

If reimbursement is requested for a plan member *other than the employee*, please provide the dependent's information below:

Last Name	*First Name*	*MI*	*Gender*	*Date of Birth*	*Relationship*
			.		.

Provider Information

Provider's Name	*Provider's Address*	*City*	*ST*	*ZIP Code*	*Provider's Phone#*

Services Received

Please provide the following information about the services and/or equipment, supplies, etc. included in your claim:

DATE(S) OF SERVICE: From: MM/DD/YYYY To: MM/DD/YYYY	DESCRIPTION OF SERVICE(S), EQUIPMENT. SUPPLIES, ETC.	$ AMOUNT CLAIMED	HAVE YOU PAID THIS CHARGE? (Y/N)
–			.
–			.
–			.
–			.

Assignment of Benefits & Authorization

Please indicate whether payment should be issued to the plan subscriber, or to the provider listed above:

☐ **Issue Payment to the Plan Subscriber***
I have paid this bill; please reimburse me directly.
I have included proof of payment with this claim.

☐ **Issue Payment to the Provider Named Above**
I have not paid this bill; please issue payment to the provider named above.

I hereby authorize payment of the group benefits payable to me directly or to the provider shown on the attached bill or receipt for the treatment or service described. I understand I may be financially responsible for charges not covered by this assignment. I also confirm that none of the attached expenses were reimbursed under any other health coverage, including any Flexible Spending Account (FSA), Health Savings Account (HSA) or Health Reimbursement Arrangement (HRA).

I certify that the information on the form and all supporting documents are complete, accurate and unaltered.

Signature: _____ _____

Signature of Employee *Date Signed*

Submit this completed form, along with copies of your payment receipts and other supporting documentation, to:

Health Plans, Inc. • PO Box 5199 • Westborough, MA 01581
800-532-7575 • Fax 508-754-9664
www.HealthPlansInc.com