

## **CLAIM FORM**

PLEASE COMPLETE IN FULL TO ENSURE PROPER PROCESSING

NAME OF GROUP		POLICY NUMBER	
PARTICIPANT'S LAST NAME		PARTICIPANT'S FIRST NAME	MI
PARTICIPANT'S U.S. MAILING ADDRESS—NUMBER AND STREET NAME (OR P.O. BOX #), CITY, STATE, ZIP			
PARTICIPANT'S DATE OF BIRTH (MM/DD/YY)	<input type="checkbox"/> FEMALE <input type="checkbox"/> MALE	PARTICIPANT'S ID NUMBER	PARTICIPANT'S PHONE NUMBER

*If patient is a Dependent currently insured under this plan, complete information below (in addition to the above).*

PATIENT'S LAST NAME		PATIENT'S FIRST NAME	MI
PATIENT'S U.S. MAILING ADDRESS —NUMBER AND STREET NAME (OR P.O. BOX #), CITY, STATE, ZIP			
PATIENT'S DATE OF BIRTH (MM/DD/YY)	<input type="checkbox"/> FEMALE <input type="checkbox"/> MALE	PATIENT'S PHONE NUMBER	

### **SECTION 1 – TYPE OF CLAIM**

1. Is this claim pertaining to a sickness/medical condition or an injury (which may include prescription medication), or for prescription reimbursement only?
  - Prescription Reimbursement Only. Please complete **SECTION 4** and **SECTION 5**.
  - Sickness/medical condition. Please complete **SECTION 3**, **SECTION 4**, and **SECTION 5**.
  - Injury. Please complete **SECTION 2**, **SECTION 4**, and **SECTION 5**.

### **SECTION 2 – INJURY INFORMATION**

2. Date that injury occurred: \_\_\_\_\_ When was physician first consulted? \_\_\_\_\_
3. Briefly describe the type of injury (i.e., ankle sprain, broken arm, etc.) and how and where the injury occurred: \_\_\_\_\_
4. Was the injury the result of a motor vehicle accident?  Yes  No
5. Did the injury occur while at your place of work?  Yes  No If yes, please list the name and address of the employer: \_\_\_\_\_

### **SECTION 3 – SICKNESS INFORMATION**

6. Briefly describe the sickness or medical condition: \_\_\_\_\_
7. Have you suffered the same or similar condition before?  Yes  No If yes, and you were previously treated for it, date treated: \_\_\_\_\_  
Name and address of physician who treated you: \_\_\_\_\_
8. If hospitalized at that time, date confined to hospital: \_\_\_\_\_  
Name and address of hospital: \_\_\_\_\_

### **SECTION 4 – OTHER INSURANCE INFORMATION**

9. Do you have other insurance which covers your condition (group, individual, automobile, medical, or liability)?  Yes  No  
If yes, who is the Policyholder?  Self  Parent  Spouse Name of Insurance Carrier: \_\_\_\_\_  
Member No.: \_\_\_\_\_ Group No.: \_\_\_\_\_ Insurance Co. Phone No.: \_\_\_\_\_  
Primary Insured's Name (Parent/Spouse): \_\_\_\_\_

### **SECTION 5 – ASSIGNMENT OF BENEFITS**

10. Indicate below to whom payment is to be made:
  - Balance is owed to the provider of service. Please pay the provider as indicated on billing statement.
  - Expenses have been paid by the patient/participant. Please reimburse the patient/participant listed above.

**AUTHORIZATION TO RELEASE INFORMATION:** To any medical care provider, medical care facility, insurer, government-sponsored health plan, or employer, I permit (while my claim is pending) the release of any medical information about me to the Company and its representatives. The Company's representatives include reinsuring companies and other persons or groups performing business of legal services relating to my claim. This applies to all information about the diagnosis, treatment, or prognosis or any illness or injury I now have or have had in the past. The Company will use this information to find out if my claim is eligible. A copy of this authorization (one of which will be given to me by the Company upon my request) will be as valid as this one. I certify that the above information given by me in support of this claim is true and correct.

Patient's or Participant's Signature \_\_\_\_\_ Date \_\_\_\_\_

**IMPORTANT:** This form must be completed and returned to the company within 60 days from the date of treatment, accompanied by all bills incurred to that date. Please include itemized bills (see itemized bill requirements on page 2).

**PLEASE SUBMIT THIS COMPLETED FORM BY MAIL TO:** Relation Insurance Administrators, P.O. Box 6040, Agoura Hills, CA 91376-6040

# CLAIMS PROCESS

1. After you receive treatment at a PPO provider, the provider will usually submit the charges directly to the claims administrator for you. In this case, you will receive an Explanation of Benefits indicating what the insurance covered. The provider will then bill you for any remaining charges, such as your coinsurance amount. *You do not need to send balance billing statement (after the insurance has paid) for reimbursement, as that is your responsibility to pay.*
2. If you are asked to pay up front for medical treatment you receive, or if the provider does not send the claim to the claims administrator, you will need to submit a claim for the portion of the charges for which the company is responsible. Submit **itemized hospital and medical bills with a completed claim form to:**  
  
**Relation Insurance Administrators  
P.O. Box 6040  
Agoura Hills, CA 91376-6040  
Fax: (818) 735-3567**
3. If you fill a prescription, you must pay in full at the time of pick up. You will then need to submit a claim for reimbursement for the portion of the charges for which the company is responsible. Submit the **itemized prescription drug receipt** with a completed claim form to:  
  
**Relation Insurance Administrators  
P.O. Box 6040  
Agoura Hills, CA 91376-6040**
4. If you have questions regarding your claim submission, please send an email to [riainfo@relationinsurance.com](mailto:riainfo@relationinsurance.com).
5. If you have questions about the status of your claim after it has been submitted or for any questions about benefits, please call Relation Insurance Administrators at **(800) 314-3938**, Monday-Friday, 6:30 a.m. to 5:00 p.m. (4:00 p.m. on Fridays) PT.

***Always keep a copy of all documents submitted for claims.***

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## ITEMIZED BILL REQUIREMENTS

### Hospital and Medical Bills

A fully itemized billing statement is required for claims payment consideration. The itemized billing statement must include the following:

- Patient's name
- Patient's date of birth
- Provider's name
- Provider's address
- Provider's tax identification number
- Diagnosis code(s)
- Date of service
- Procedure code(s)
- Amount charged for each procedure

**Note: If your billing statement does not include this information, please contact the provider and ask them to send a copy to you to include with this form. (The fully itemized billing form is also known as a HCFA 1500, CMS 1500, UB04, and CMS 1450.)**

### Prescription Drug Receipts

A fully itemized prescription drug receipt is required for claims payment consideration. The prescription drug receipt must include:

- Pharmacy name
- Prescription (Rx) number
- Patient's name
- Name of the medication(s)
- Prescribing physician's name
- Dosage or quantity dispensed
- NDC code number
- Date of service
- Amount charged

**Note: Please do not send a cash register receipt listing only the charges. You must send the full receipt or print-out that includes all of the above.**

***If you (or the medical provider) do not provide the Rx receipt as indicated above, your claim may be denied until the information is provided.***