Request for Payment of Medical Services

Request for payment to:

❑ Doctor or provider ❑ Subscriber (Proof of payment must be included; see reverse.)

MEMBER INFORMATION *(required)*			
First name	Middle initial	Last name	Date of birth MM/DD/YYYY
Street			
City		State	ZIP
Member ID number	Home telephone ( )	Work telephone ( )	Sex ❑ Male ❑ Female

PHYSICIAN OR PROVIDER OF SERVICE INFORMATION *(required)*	
Provider or facility where services received	NPI and tax ID number of provider of service
Address of provider or facility where services received	
Name of referring physician (if applicable)	

DIAGNOSIS *(required)*		
Date of service MM/DD/YYYY	**Charge**	**Amt. paid**
Provider of service		
Description of service		

INTERNATIONAL SERVICE INFORMATION (Complete if service was outside the U.S.)	
Country where services were rendered	Language of documentation
Currency paid	How was payment made? (e.g., check, credit card, cash)

OTHER INSURANCE

Are you covered by other insurance (other than Medicare and/or Medicaid)? ❑ Y ❑ N

If yes, number: _____

Name and address of carrier _____

Is the claim due to

- an automobile accident? ❑ Y ❑ N Please explain: _____
- any other type of accident? ❑ Y ❑ N Please explain: _____
- an occupational injury or illness? ❑ Y ❑ N

Comments: _____

AUTHORIZATION RELEASE

I, the undersigned, hereby authorize any physician, hospital, insurer, or other organization or person having any medical or other records, data or information concerning me or my minor dependent to furnish such records, data or information to Fallon Health. I understand that in executing this authorization, I waive all claim and right of privilege with regard to such information. A photocopy of this authorization shall be considered as effective and valid as the original bearing my signature.

Member/Authorized Representative signature _____

Date _____

See reverse for instructions.

Instructions for submitting your Request for Payment of Medical Services

Follow these easy steps:

1. **Check** the appropriate box showing whether you want payment sent to the doctor or to you. If you want payment to go directly to you, **attach some proof of payment such as a canceled check (front and back) or paid receipt with a copy of your bank/credit card statement.** If you paid cash, include a paid receipt. Remember to make a copy for your records.

   For international claims: If you paid cash, please include a copy of the source of the cash such as proof of wire transfer, traveler check receipt or your bank/credit card statement. All documentation must be translated into English.
2. **Complete** the "Member Information" section showing your name, member ID number and other identifying information.
3. **Complete** the "Physician or Provider of Service Information" section. Attach copies of itemized bills from the doctor or other provider. **Your request cannot be processed without the provider's NPI and tax ID number.** If this information is not on your receipt, please call the provider for this information. NPI and tax ID numbers are not required for international claims.
4. **Complete** the "Diagnosis" section. The amount paid must match your proof of payment documentation.
5. If this is an international claim, **complete** the "International Service Information" section.
6. **Complete** the **"**Other Insurance**"** section providing all information on other health insurance (if applicable), such as coverage for an automobile accident, other accident or occupational illness/injury (workers' compensation). Please do not include Medicare and/or Medicaid coverage.
7. **Sign and date** the Authorization Release.

With complete information, payment will be received within 4–6 weeks.
We will contact you in writing if we need additional information regarding your claim.

After completing the form, please mail or email it with receipts to:

Fallon Health
P.O. Box 211308
Eagan, MN 55121-2908

Email: reimbursements@fallonhealth.org

For questions:

Fallon Medicare Plus™ members and Fallon Medicare Plus™ Central members, please call Customer Service at 1-800-325-5669 (TRS 711).

NaviCare® HMO SNP or SCO members, please call Enrollee Services at 1-877-700-6996 (TRS 711).

We are open 8 a.m.–8 p.m., Monday–Friday. (Oct. 1–March 31, seven days a week.)

To receive payment, forms must be submitted to us within 365 days of the date of service.

H9001_220621_C, H8928_220545_C Approved 11152021
21-660-016 Rev. 00 10/21

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