



General instructions: Make sure you and your physician or other health care professional fill out this form completely in order for you to receive timely reimbursement for paid medical services.

- Type or print requested information.
Ask your provider(s) to help you complete all information in sections C and D.
Attach itemized receipts or claim forms for each service. (Do not staple items.)
A separate reimbursement request form should be completed for each patient.
Please keep a copy of each itemized bill or receipt for your records.
Do not submit a form if your physician or other health care professional is also filing a claim to IU Health Plans for the same service.

GROUP NO. (FROM I.D. CARD)

MEMBER IDENTIFICATION NO. (FROM I.D. CARD)

A. PATIENT INFORMATION

PATIENT NAME (Print) SEX M F BIRTHDATE

RELATIONSHIP TO TEAM MEMBER: SELF CHILD SPOUSE OTHER

B. TEAM MEMBER INFORMATION

TEAM MEMBER NAME Check if new address

TEAM MEMBER ADDRESS City State Zip

C. PROVIDER INFORMATION

PROVIDER NAME TAX ID NUMBER NPI NUMBER

PROVIDER ADDRESS City State Zip

D. SERVICE INFORMATION

Table with 6 columns: Date (mm/dd/yy), Place of Service, Codes for procedures, services or supplies, Diagnosis Code, Charges, Number of Units. Includes Total Charges and Amount paid by you at the bottom.



E. OTHER INSURANCE INFORMATION

IS PATIENT COVERED BY ANOTHER MEDICAL PLAN? YES NO
IF YES, INDICATE MEDICAL PLAN NAME POLICY NUMBER
IDENTIFICATION NUMBER EFFECTIVE DATE OF COVERAGE
NAME, ADDRESS AND PHONE # OF OTHER CARRIER
EMPLOYER'S NAME Phone TEAM MEMBER BIRTH DATE
SPOUSE BIRTH DATE
IF YOU ARE ELIGIBLE FOR MEDICARE:
• Submit bills for all charges except prescription drugs to Medicare first.
• You will receive the Explanation of Benefits Statement from Medicare...
• Some physicians and other medical providers will file your Medicare claims directly for you.

F. PATIENT AUTHORIZATION

To all physicians and other medical professionals, hospitals and other medical care institutions, and to insurers, medical or hospital service and prepaid health plans, employers and group policyholders, contract holders or benefit administrators:
• You are authorized to provide any benefit plan administrators, consumer reporting agencies, attorneys and independent claim administrators acting on IU Health Plans' behalf, with information regarding the Patient.
• I hereby authorize IU Health Plans to provide the information relating to medical services and treatment rendered to me and/or my dependents.
• I understand that the duration of the authorization is for the term of coverage of the policy or contract under which a claim for health benefits has been submitted.
• I have furnished the information on this form so that IU Health Plans may consider this claim.
• Should there be an overpayment in excess of the amount payable under the Medical Plan, I agree to reimburse IU Health Plans to the extent of the overpayment.

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE RELATIONSHIP OF AUTHORIZED PERSON DATE

G. PAYMENT AUTHORIZATION

PAY TO PROVIDER PAY TO ME
I authorize benefits to be paid directly to the physician or other provider of service.
I authorize benefits to be paid to me. I understand it is my responsibility to pay the physician, hospital, or other provider of service.
EMPLOYEE / RETIREE / SURVIVOR SIGNATURE DATE EMPLOYEE / RETIREE / SURVIVOR SIGNATURE DATE

Before you submit your claim.....
1. Be sure that all fields are completed.
2. Make photocopies of all receipts and completed forms. Receipts will not be returned.
3. Write your IU Health Plans Member ID number on all paperwork you submit.

SUBMIT TO
IU Health Plans
P.O. Box 627, Columbus, IN 47202-0627
Toll Free in Indiana 1-800-873-2022