KAISER PERMANENTE®

Kaiser Foundation Health Plan, Inc.
California

CLAIM FOR EMERGENCY MEDICAL SERVICES

For complete information about your emergency benefits or applicable copayments, deductibles, or coinsurance that are your responsibility, please refer to your *Evidence of Coverage* booklet.

Note: If your primary health coverage is through another medical plan, you must file your claim with that plan first. If there is a balance remaining after your primary medical plan decides your claim, you may file a claim for Kaiser Foundation Health Plan to pay the difference. Complete the attached Claim for Payment of Emergency Medical Services form and mail it along with a copy of your other plan's Explanation of Benefits. Also attach a copy of all related itemized bills. Please refer to your *Evidence of Coverage* for additional information.

Instructions

To request reimbursement for emergency services received at a non–Kaiser Permanente facility:

1. Complete both sides of the attached Claim for Payment of Emergency Medical Services form.
2. Attach all applicable additional information that is requested on the back of the claim form.
3. Date and sign the form.
4. Detach and keep this instruction sheet and make a copy of the Claim for Payment of Emergency Medical Services form for your records.
5. Mail your completed form, along with any itemized bills, to one of the following addresses:

For Southern California Members:
Kaiser Foundation Health Plan, Inc.
Claims Department
P.O. Box 7004
Downey, CA 90242-7004

For Northern California Members:
Kaiser Foundation Health Plan, Inc.
Claims Department
P.O. Box 12923
Oakland, CA 94604-2923

We will process your claim upon receipt of this completed form. If we need additional information, we will notify you. For information about our time frames for processing your claim, please refer to your *Evidence of Coverage*.

If you have any questions or need assistance, please call our claim services at **1-800-390-3510.**

KAISER PERMANENTE®

Kaiser Foundation Health Plan, Inc.
California Division

Required

MR#: _____

Name: _____

CLAIM FOR EMERGENCY MEDICAL SERVICES

IN ORDER FOR YOUR CLAIM TO BE CONSIDERED FOR PAYMENT:

- BOTH SIDES OF THIS FORM MUST BE COMPLETED IN FULL.
- ALL ITEMIZED BILLS FOR THIS EMERGENCY MUST BE ATTACHED.
- THIS FORM MUST BE SIGNED; SEE BELOW.
- IN MOST CASES, PAYMENT WILL BE MADE TO PROVIDER(S) UNLESS PROOF OF PAYMENT IS FURNISHED BY THE MEMBER OR PROVIDER(S).
- FOREIGN CLAIM PAYMENTS WILL BE MADE TO THE MEMBER WHEN DOCUMENTED PROOF OF PAYMENT IS FURNISHED BY THE MEMBER, AND/OR POWER OF ATTORNEY, ESTATE OR FINANCIAL DESIGNEE, WHEN PROPERLY IDENTIFIED FOR DECEASED MEMBERS, IS PROVIDED.

PATIENT NAME	LAST	FIRST	INIT	SEX	BIRTH DATE

PATIENT ADDRESS	STREET	CITY	STATE	ZIP

SUBSCRIBER NAME	LAST	FIRST	INIT	RELATION TO PATIENT	PATIENT DAY TELEPHONE
					( )

SUBSCRIBER ADDRESS	STREET	CITY	STATE	ZIP

PLACE OF ILLNESS/INJURY	CITY	STATE/COUNTRY	INCIDENT DATE	TIME
				☐ a.m. ☐ p.m

PLACE OF EMERGENCY CARE	CITY	STATE/COUNTRY	TREATMENT DATE	TIME
				☐ a.m. ☐ p.m

IS PATIENT COVERED BY MEDICARE OR OTHER MEDICAL INSURANCE?	NAME OF POLICY HOLDER/SUBSCRIBER
☐ Yes ☐ No	

IF YES, INSURANCE COMPANY NAME	ADDRESS	TELEPHONE	SUBSCRIBER ID NUMBER

INSURANCE COMPANY NAME	ADDRESS	TELEPHONE	SUBSCRIBER ID NUMBER

IS MEDICAL COVERAGE PART OF THE CAR INSURANCE POLICY?	NAME OF POLICY HOLDER
☐ Yes ☐ No	

IF YES, AUTOMOBILE INSURANCE COMPANY NAME	ADDRESS	TELEPHONE	POLICY NUMBER

MEMBER'S DESCRIPTION OF HOW THE EMERGENCY OCCURRED

WHY WAS THE PATIENT NOT TREATED AT A KAISER PERMANENTE FACILITY?

WAS AN AMBULANCE USED?	WHO CALLED THE AMBULANCE?
☐ Yes ☐ No	☐ Patient ☐ Kaiser Permanente ☐ Police/Fire ☐ Other (specify) _____

IF HOSPITALIZED:	ADMIT DATE	DISCHARGE DATE	IS THE PATIENT DECEASED? ☐ Yes ☐ No DID THE PATIENT DIE AS A RESULT OF THE EMERGENCY? ☐ Yes ☐ No

I authorize _____ (names of providers) to release any and all information, including medical and/or hospital records pertaining to the health care services provided to me on/between the dates listed on this Claim for Emergency Medical Services. I understand that this information is necessary to allow Kaiser Foundation Health Plan, Inc., to process my claim for payment of these services.

AUTHORIZING SIGNATURE: PARENT'S SIGNATURE IF PATIENT IS A MINOR	DATE SIGNED

Required

MR#: _____

Name: _____

CLAIM FOR EMERGENCY MEDICAL SERVICES (Continued)

WHEN DID YOU NOTIFY KAISER PERMANENTE?	WITH WHOM DID YOU SPEAK?
NAME OF YOUR KAISER PERMANENTE DOCTOR	AT WHICH KAISER PERMANENTE MEDICAL OFFICE DO YOU RECEIVE YOUR REGULAR CARE?

WAS THE INJURY OR ILLNESS WORK-RELATED?

☐ Yes ☐ No

IF YES, PLEASE ATTACH EXPLANATION OF PAYMENT OR DENIAL FROM THE WORKERS' COMPENSATION CARRIER.

WAS THIS INJURY THE RESULT OF A MOTOR VEHICLE ACCIDENT?

☐ Yes ☐ No

IF YES, PLEASE SEND A COPY OF THE AUTO POLICY FACESHEET FOR THE VEHICLE IN WHICH THE PATIENT WAS RIDING. PLEASE SPECIFY WHETHER THE PATIENT WAS THE DRIVER OR PASSENGER.

WAS THIS INJURY CAUSED BY SOMEONE ELSE?	IF YES, NAME OF PARTY AGAINST WHOM YOU HAVE A CLAIM	POLICY NUMBER
☐ Yes ☐ No		

PARTY'S INSURANCE COMPANY NAME AND ADDRESS

If you have retained an attorney, please give the attorney's name, address, and phone number

ATTORNEY'S NAME	ADDRESS	TELEPHONE
		( )

Please be sure to include the following information to help expedite the claim.

Attach all applicable additional information that is requested on this form and make a copy of that information for your records.

Please make sure to include your name and medical record number on each document and submit the following information: documentation of power of attorney, estate or financial designee for deceased members, if applicable, so that we may process your claim.

The following information is required for all claims:

- Itemized bills
- Medical records and/or reports that you may have in your possession or to which you have access to receipts of payment
- Medical record number (that matches the medical record number on your Kaiser Permanente ID card)

Foreign claim reimbursement requirements:

1. Proof of payment: receipt or bank statement, copies of original checks (front and back)
2. Proof of pharmaceutical payment: include with claim form and provide copies
3. Proof of travel: travel documentation, for example, copy of travel itinerary and/or airline tickets
4. Diagnosis noted on claim form
5. Copies of original itemized bills of service—professional, hospital, and pharmaceutical
6. Applicable supporting medical records: copies of original medical report, admission notes, emergency room records, and consultation report—**if possible, translated in English prior to submission**