Ascension
Personalized Care

Self-reimbursement claim form

INSTRUCTIONS FOR FILING A MEDICAL CLAIM — Please read before completing the form on the next page.

1. This form is only needed to submit claims for services and supplies that are not submitted by your doctor or supplier (i.e., out-of-network doctors and hospitals). You must file your claim within one year from the date of service. You can submit your claim any time during the year. Payment of benefits are subject to all terms, conditions and limitations and exclusions of the contract with Ascension Personalized Care benefits at the time of service. Completion of the form does not guarantee payment. ***The form must be filled out completely for processing.***
2. Use a separate claim form for each family member and each doctor or supplier.
3. All sections of the form must be filled out completely or your claim may be returned to you.
4. If your claim is a result of a motor vehicle accident, please provide a copy of the auto carrier's Explanation of Benefits or Letter of Exhaustion (if available).
5. If you have other insurance, please provide a copy of your ID card(s). Please send a copy of Explanation of Benefit statements from the other insurance company for the claim you are submitting (i.e., health or auto).
6. If your claim is for durable medical equipment (i.e., wheelchair, respirator, oxygen, etc.), you must submit the prescription along with a letter of medical necessity from the treating doctor.
7. Your original itemized bills and receipts must include:

   - ⬜ Doctor or supplier name
   - ⬜ Doctor or supplier address
   - ⬜ Doctor or supplier Tax ID or NPI (National supplier Identifier) Number
   - ⬜ Policy holder (member) name
   - ⬜ Patient's full name
   - ⬜ Type of service and procedure code
   - ⬜ Date of service or purchase
   - ⬜ Diagnosis and diagnosis code
   - ⬜ Condition being treated
   - ⬜ Charge for each service

   Please note: The following are **not** acceptable documents: cash register receipts, cancelled checks, money order receipts or personal lists. You must submit original bills or receipts from your doctor or supplier. Please keep a copy as the originals cannot be returned.
8. If this claim is for a non-contracted doctor or supplier, no payment will be made to you or your doctor. This plan does not cover services rendered to non-contracted doctors or suppliers unless related to a "true" emergency situation.
9. Please be sure to review your claim form and documents carefully to ensure we can process your claim accurately and quickly.

Mailing address

Please mail your completed claim form with original bills or receipts and copies of other Explanation of Benefits, if applicable, to:

Ascension Personalized Care
P.O. Box 1707
Troy, MI 48099-1707

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MEDICAL CLAIM FORM (To be completed by member.)

- Complete **all** information or your form may be returned.
- This form only needs to be completed if the doctor or supplier is not submitting on your behalf.
- Use a separate form for each family member and each doctor or supplier.
- Enclose **original** itemized bills. Keep a copy for your records.
- Mail to: **Ascension Personalized Care, PO Box 1707, Troy, MI 48099-1707**

See previous page for additional instructions.

Member's information (The policy holder name shown on the front of your ID card.)

Member's legal name (Last, First, Middle Initial)			Date of Birth - MM DD YYYY
Member's street address, check box if new address ☐	City	State	Zip Code
Member / contract number	Group number	Employer name (if applicable)	

Patient's information

Patient's legal name (Last, First, Middle Initial)	Date of Birth - MM DD YYYY
Patient's relationship to member: ☐ Self ☐ Spouse ☐ Child ☐ Other	**Patient's sex** ☐ Male ☐ Female

Patient's medical information (May be found on Itemized bill or receipt)

	Date of service / visit			Nature of visit / diagnosis code	Procedure code(s)	Doctor or supplier information
1	MM	DD	YYYY			Name Address Zip Code Phone Number
2	MM	DD	YYYY			
3	MM	DD	YYYY			

Was the treatment the result of an accidental injury? ☐ Yes ☐ No Or work related? ☐ Yes ☐ No

Description of how accident or work related illness/injury occurred:
Please note: If this was an auto accident please include a copy of your auto carrier's Letter of Exhaustion. If this is work related, please provide a work related illness/injury report.

_____

_____

Date of accident or beginning of illness:

Other coverage information (If yes, include a copy of your ID card from Medicare or other insurance company)

Is the patient covered under any other insurance policy providing health care benefits or services? ☐ Yes ☐ No

Name on other policy:	Name of insurance:	Policy number:

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Authorization and signature required

I certify the above is complete and correct and that I am claiming benefits only for charges incurred by the patient named above. Authorization is hereby given to any hospital, doctor, or other supplier which participated in any way in my care and treatment to release any medical information which they in their judgment deem necessary to the adjudication of this claim.

Please note: Any person who knowingly and with intent to injure, defraud, or deceive any insurance company files a statement of claim containing any false, incomplete or misleading information is guilty of a felony of the third degree.

Signature of policy holder:_____ Date: _____

Authorization of payment to non-contracted doctors or suppliers (Signature required if payment is to be sent to the doctor(s) above.)

I authorize Ascension Personalized Care to make payment of benefits directly to the doctor(s) or supplier(s) indicated on the enclosed bills/receipts in those situations that constitute emergency medical services where such doctor(s) or supplier(s) is/are a non-contracted doctor(s) or supplier(s) and member domiciled state law requires direct payment when authorized.

Please note: Should any such doctor or supplier also submit a claim for the same services and inform us that the benefits have been assigned, we may honor that assignment should the authorization on this form be signed or not signed.

Signature of policy holder _____ Date: _____