

IMPORTANT: Please be sure to include all information requested. Missing information will delay the processing of your claims.

This claim form is to be used by enrolled employees and their dependents when requesting payment for medical services.

- Please:**
1. Complete the form. Refer to your member card for the member number.
 2. If you have questions related to the claim or completion of the form, please call (952) 883-7755.
 3. Attach itemized medical bills.
 4. Send the completed form **within 15 days** to:

HealthPartners
 P.O. Box 1289
 Minneapolis, MN 55440-1289

Patient Name: _____ Relationship to Policyholder _____

Member Number: _____

INSURANCE INFORMATION UPDATE

HealthPartners Policyholder name _____		
Name of Spouse of Policyholder _____	Spouse Date of Birth _____	
Is Policyholder's spouse employed?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
If YES, Name of Employer _____		
Is Policyholder's spouse covered under his/her employer's health plan	<input type="checkbox"/> YES	<input type="checkbox"/> NO
If YES, complete the following:		
Name of other insurance company _____	Phone Number _____	
Address _____		
Policy/Group # _____	Effective Date _____	
<input type="checkbox"/> Single coverage	<input type="checkbox"/> Family coverage	
1. Was this care a result of an Accident/Injury?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
2. Was the illness related to your work, motor vehicle, or any other third party?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
3. Is patient covered by another medical policy not listed above?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
4. Is the Policyholder or Spouse of Policyholder covered by any other medical policy not listed above?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
5. Is the Policyholder or Spouse of Policyholder divorced and/or remarried with dependents?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
<p>If you answered YES to either questions number 1 or 2, please complete Section A on reverse side.</p> <p>If you answered YES to either questions number 3, 4, or 5, please complete Section B on reverse side.</p> <p>If you answered NO to all of the above questions, please sign, date and return.</p>		

I HEREBY DECLARE THE ABOVE INFORMATION TO BE TRUE AND ACCURATE.	
HealthPartners Policyholder signature _____	Date _____

Section A
ACCIDENT OR ILLNESS INFORMATION UPDATE

Date of original illness or injury resulting in this claim (if unknown, date first seen by a doctor) _____

If illness, please describe _____

If injury, give details of how injury occurred _____

Where did injury occur? _____

OTHER PARTY INSURANCE COVERAGE

Type of coverage related to the injury:

- Automobile Personal Injury Work Related
 Homeowners Liability Other (please describe)

If you checked any of the above, please provide the following: _____

Person or establishment with possible financial responsibility for the injuries

Name _____

Address _____ Phone number _____

Responsible insurance carrier, if known _____

Address _____ Phone number _____

Attorney, if one is retained

Name _____ Phone number _____

Section B

If Policyholder, Spouse, or Dependent(s) are covered by another medical policy, please complete the following:

Name of person covered	Health plan name, address and phone number	Policyholder name and policy number	Effective Date
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____

If you are divorced and/or remarried with dependents, please complete the following:

Child's complete name	Name of person(s) with legal custody	Name and date of birth of person(s) responsible for dependent health care expenses per divorce decree
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____

Are any of the children listed above also covered under another health insurance plan? YES NO

If YES, please complete the following:

Name of person covered	Health plan name, address and phone number	Policyholder name and policy number	Effective Date
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____

If additional space is needed for any section, please provide on a separate page.

COORDINATION OF BENEFITS AND UTILIZATION /CLAIMS REPORTING AUTHORIZATION

I authorize HealthPartners to release general medical information regarding my family's treatment to the administrators of any other health plan providing coverage to me or my dependents. I authorize the administrators of any other health plan providing coverage to me or my dependents to release information to HealthPartners regarding health care benefits to which we may be entitled. I understand that the purpose of the release of information is to assure proper coordination of benefits of all plans. I understand that HealthPartners may release information regarding services provided under my health benefits contract when requested by the employer/organization sponsoring my health benefits plan. This information will be reported without identification of individuals to maintain patient confidentiality. This authorization shall remain valid for the duration of the coverage of the plan for which a claim is submitted. I understand a photocopy of this authorization shall be as valid as the original.

I UNDERSTAND THAT A PERSON WHO FILES A CLAIM WITH INTENT TO DEFRAUD OR HELPS COMMIT A FRAUD AGAINST AN INSURER IS GUILTY OF A CRIME. I HEREBY DECLARE THE ABOVE INFORMATION TO BE TRUE AND ACCURATE.

HealthPartners Policyholder signature _____ Date _____

Thank you for your cooperation. We will hold your claim open for fifteen days to allow you time to submit the necessary information. If you have any questions related to the claim or completion of this form, please call (952) 883-7755.