Valley Health Plan

www.valleyhealthplan.org

MEDICAL CLAIM REIMBURSEMENT FORM

SUBSCRIBER (EMPLOYEE) INFORMATION

Subscriber's Last Name	Subscriber's First Name	M.I.	Social Security Number	VHP ID Number
			- -	

Date of Birth / /	Subscriber's Home Address (Street)			Do you or the patient have other health insurance coverage, including Medicare or Medi-Cal? ❑ No ❑ Yes - If YES, give name, address and policy number of health insurance coverage:
Home Phone Number ( ) -	City	ST	Zip Code	

PATIENT INFORMATION - (If the Patient and Subscriber are the same, the below patient information does not have to be completed.)

Patient's Last Name	Patient's First Name	M.I.	Patient's relationship to Subscriber: ❑ Self ❑ Spouse/Domestic Partner ❑ Child ❑ Other

Date of Birth / /	Patient's Home Address (Street)	City	ST	Zip Code

CLAIM INFORMATION

Nature of Illness/Reason for Services (If needed, use separate sheet to describe):	Why were you unable to use one of the VHP contracted pharmacies/providers/ etc.?

Was VHP contacted for Authorization? ❑Yes ❑No	Was the service(s) referred by: ❑PCP ❑Physician ❑Pharmacy ❑Other: ______________________

Date of Service / /	Provider of Service	Amount Paid for Service $
If needed, use separate sheet to list all services provided.	**TOTAL**	Amount Paid for All Services $

Is this a work injury - Workers Compensation (WC) or caused by an automobile or other type of accident? ❑No ❑Yes - If YES, complete the following:

Date of Accident / /	Name of Auto Insurance or Workers Compensation Carrier	Auto or Workers Comp Claim #

Describe how, when, and where the accident occurred:	Are any of the illnesses or injuries for which this claim is being made related to your job/employer? ❑Yes ❑No
	Are you entitled to reimbursement for all or part of these expenses through any other coverage that provides medical benefits or services? ❑Yes ❑No If YES, please provide other coverage information.

AUTHORIZATION SIGNATURE FOR RELEASE OF INFORMATION

I hereby authorize any insurance company, organization, employer, hospital, physician, surgeon, or pharmacy to release information requested by Valley Health Plan. A photocopy of the authorization shall be considered as effective and valid as the original.

Subscriber or Parent (Employee) Signature. For minor children, a parent must sign. **X**	Date

For your protection, California law requires that the following statement be included on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison. If approved, a reimbursement check will be sent payable to the Subscriber at the address on file with VHP or as applicable to Provider within 45 working days.

How To File A Medical Claim Reimbursement Form

Medical Claim Reimbursement Forms must be submitted to Valley Health Plan within **ninety (90) days of the date of service**.

Step 1: Fill out a Medical Claim Reimbursement Form

Step 2: Include original receipts, bills, invoices, and proof of payment.

- Original receipt(s) including
  - Name of patient;
  - Name of doctor, hospital, or other provider;
  - Date paid; and
  - Amount paid.
- Original itemized bill(s) or invoice(s) from provider including:
  (If in the event of a foreign receipt, payment will be calculated based on dollar conversion rate at the time of service)
  - Name of patient;
  - Date(s) of service; and
  - Nature of illness or injury - including medical and hospital billing code(s).
- Proof of payment
  - Other proof of payment, such as a copy of a cashed check or credit card receipt may be required.

Step 3: Mail or walk-in the completed Medical Claim Reimbursement Form with receipts, bills, invoices, and medical records within ninety (90) days of the date of service to:

Valley Health Plan
Attention: Member Services
2480 N. First Street, Suite 200
San Jose, CA 95131

Step 4: Upon approval of your request, a check will be mailed to you within forty-five (45) working days of the receipt of your request.