HealthPartners®

CLAIM FORM

HealthPartners
PO BOX 1289
Minneapolis, MN 55440-1289

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? ❑ YES ❑ NO

If YES, Name of Employer _____

Is Policyholder's spouse covered under his/her employer's health plan ❑ YES ❑ NO

If YES, complete the following:

Name of other insurance company _____ Phone Number _____

Address _____

Policy/Group # _____ Effective Date _____

❑ Single coverage ❑ Family coverage

1. Was this care a result of an Accident/Injury? ❑ YES ❑ NO
2. Was the illness related to your work, motor vehicle, or any other third party? ❑ YES ❑ NO
3. Is patient covered by another medical policy not listed above? ❑ YES ❑ NO
4. Is the Policyholder or Spouse of Policyholder covered by any other medical policy not listed above? ❑ YES ❑ NO
5. Is the Policyholder or Spouse of Policyholder divorced and/or remarried with dependents? ❑ YES ❑ NO

If you answered **YES** to either questions number **1** or **2**, please complete **Section A** on **reverse side.**

If you answered **YES** to either questions number **3**, **4**, or **5**, please complete **Section B** on **reverse side.**

If you answered **NO** to all of the above questions, please sign, date and return.

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

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.