HEALTH TRADITION
P.O. Box 21191 | Eagan, Minnesota 55121 | 877.832.1823 | healthtradition.com

Member Reimbursement Claim Form

Please do not use this form for International Claims

Instructions for Submitting Claims

1. Submit a claim only when you are billed for services from a provider that does not directly submit a claim to Health Tradition.
2. Submit a separate form for each patient.
3. Attach an **original** itemized bill from your provider (required information is on the second page of this form).
4. Keep a copy of all bills and claim forms submitted (originals will not be returned).
5. Be sure to sign and date the completed form.
6. **Claims must be submitted within 90 days of the date of service.**
7. **Mail this claim form and all attachments to: Health Tradition**
   PO Box 21191
   Eagan, MN 55121

Requested Reimbursement Amount

$

Please complete using black ink only

Subscriber (plan holder) Information

Subscriber Identification # _____ Last Name _____ First Name _____ Middle Initial _____

Address (number and street) _____ City _____ State _____ Zip Code _____

Date of Birth (MM/DD/YY) _____ Group Number/Group Name _____

Patient Information

Patient Last Name _____ First Name _____ Middle Initial _____ Date of Birth (MM/DD/YY) _____

Gender: ☐ Male ☐ Female

Patient is: ☐ Subscriber (plan holder) ☐ Child/Dependent ☐ Spouse (of plan holder) ☐ Other (specify) _____

Other Coverage

Does the patient have other insurance?

☐ No
☐ Yes

If Yes: (write effective date below)

☐ Medicare Part A (Hospital)_____
☐ Medicare Part B (Medical)_____
☐ Medicare Part D (Pharmacy)_____
☐ Other Insurance Plan_____

Identification number on other insurance plan_____

Auto insurance policy number_____
Name and address of other insurance_____

Was the treatment for . . .

An accident at work?

☐ No
☐ Yes, date of accident_____

Auto accident?

☐ No
☐ Yes, date of accident_____
☐ Yes, name of auto insurance_____

Other accident?

☐ No
☐ Yes, date of accident_____

I authorize the release of any medical or other information necessary to process this claim.

Signature _____ Date _____

Please allow up to 30 days for your claim to process

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Filing Claims

- **You will need to submit an itemized bill that must contain the following required information.**

  1. A billing statement from the provider that MUST include all of the following:
     - Provider name
     - Provider address
     - Provider Tax Identification Number/National Provider Identification Number
     - Provider credentials, i.e., the initials associated with the educational degrees the provider has earned, such as MD
  2. Patient's name
  3. Date(s) of service
  4. Itemized charges for each date of service and type of service received
  5. Procedure codes (CPT/HCPCS/Revenue codes) for all services received
  6. Diagnosis code(s) for services received
  7. Number of units (this is the number of times a service was performed on a particular date of service)

- **Attach any related claim summaries or Explanation of Benefits Forms you may have received for these services, including those received from Medicare or other insurance companies.**

- **When submitting a reimbursement request for diabetic supplies, you must submit an itemized receipt from your pharmacy that includes:**
  - National Drug Code
  - Name of Drug
  - Date dispensed
  - Quantity dispensed
  - Name of prescribing physician

- **Please provide proof of payment (a copy of the canceled check or a receipt that indicates payment was made by the member).**

PLEASE NOTE: **Any prescriptions submitted to Health Tradition in error will be returned to you.**

Claims must be submitted within
90 days of the date of service.