# Scripps Health Plan

Member Claim Reimbursement Form

This form is for direct reimbursement to Members for covered **medical** benefits under Scripps Health Plan

## 1. Subscriber and Patient Information

| | | | |
|---|---|---|---|
| Subscriber's Name (please print) | | Member ID Number | |
| Subscriber's Address | City | State | Zip |
| Patient's Name – *if different from Subscriber* (please print) | Relationship to Subscriber ☐Spouse ☐Child | Sex | Date of Birth / / |
| Patient's Address – *if different from Subscriber* | City | State | Zip |

## 2. Accident / Occupation Claim Information

| | | |
|---|---|---|
| Only complete this section if you are filing a claim because of an accident or occupational (Work-related) illness or injury. | | |
| Is this claim due to workplace accident or illness? ☐Yes ☐No | Is the claim due to an auto accident? ☐Yes ☐No | Date of accident or onset of illness Date (MM/DD/YYYY) |
| Description of how accident-work injury occurred | | |
| Are you or your dependents filing a claim or lawsuit against a third party including an insurance company in order to recover the cost of expenses incurred as a result of this accident or illness? ☐Yes ☐ No | | |
| Is a third party, including an insurance company, responsible for covering the cost of expenses incurred as a result of this accident or illness? ☐Yes ☐No | | |

## 3. Additional Coverage Information

| | | |
|---|---|---|
| Does the patient have other coverage? ☐Yes ☐No | If yes, please complete all fields in this section. | |
| Name of Other Insurance Carrier (please print) | Insurance Carrier Phone Number | Plan Effective Date / / |
| Subscriber's Name (please print) | Employer Group Number | Member ID Number |

## 4. Authorization

**IMPORTANT: When a health care professional holds a Scripps Health Plan (SHP) contract, SHP will always pay the health care professional directly, even if this section is left unsigned. The health care professional is paid at the contracted rate. If you already paid the health care professional for the services you received, you should ask your health care professional to pay you back.**

Any person who knowingly and with intent to defraud any insurance company or other person: (1) files an application for insurance or statement of claim containing any materially false information; or (2) conceals for the purpose of misleading, information concerning any material fact thereto, commits a fraudulent insurance act which is a crime. For your protection, California law requires the following to appear on/with 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.

**I certify that the information provided herein is true and correct.**

| | |
|---|---|
| Patient's Signature | Date (MM/DD/YYYY) |

# Scripps Health Plan

## Member Claim Reimbursement Form

This form is for direct reimbursement to Members for covered **medical** benefits under Scripps Health Plan

*You only need to complete this if your health care provider is **NOT** filing a claim for you. Out-of-network providers are able to submit claims to Scripps Health Plan on your behalf. This is form is **NOT** to be used for prescription drug reimbursements. Please complete the Medimpact Commercial Prescription Drug Claim Form for prescription reimbursement requests.*

For payment reimbursement, complete the below fields **AND** attach an itemized bill or statement **AND** proof of payment.

| Name of treating doctor or other health care provider (please print) | Telephone Number |
|---|---|
| Address of treating doctor or other health care provider (please print) | Tax ID Number |
| Signature of treating doctor or other health care provider | Date (MM/DD/YYYY) |

**Description of Services to be Reimbursed**

| Date of Service (MM/DD/YYYY) | Procedure Code | Description of Service | Billed Amount |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

| Diagnosis Codes and/or Description of what you were treated for | Total Charge $_____<br>Amount Paid $_____<br>Balance Due $_____ |
|---|---|

If you are submitting a claim for services performed outside of the United States, please provide the following information:
What Country were services performed in? _____
What currency were you billed in? _____ In what setting did you receive care? ☐Office / Clinic ☐ER ☐Urgent Care ☐Hospital

I have attached one of the following proofs of payment:
□ The front and back of the cleared check written to the provider, or bank encoded copy of the front of the check written to the provider
□ A copy of a credit card statement that includes the charges and the provider's name.
□ A copy of the receipt, with the provider's name and address preprinted on the receipt.

**Member Reimbursement Mailing Information**

**Mail or fax this form and COPIES of your itemized receipts to:** Scripps Health Plan
c/o Direct Member Reimbursements
10790 Rancho Bernardo Rd. 4S-300
San Diego, CA 92127
Fax: 858-964-3102

**Did you remember?**
- □ To **complete** all applicable sections on this form?
- □ To attach **COPIES** of the itemized receipts for each item listed above?
- □ To attach **COPIES** of proof of payment?
- □ To **sign and date** this form?
- □ To make a **copy** of this form and your receipts to keep for your records?

Please allow up to 45 business days for your Member Reimbursement request to be completed **upon receipt of all required documentation.** You may check status of your Member Reimbursement by calling Scripps Health Plan Customer Service at **(844) 337-3700** or for the hearing and speech impaired TTY: **(888) 515-4065**.