

Medical Reimbursement Claim Form

P.O. Box 709718
Sandy, UT 84070-9718
(844) 234-4472



Thank you for choosing MotivHealth Insurance Company for your health care coverage. Please review the filing instructions located at the end of this form before you begin for helpful information regarding how to complete your claim so that it will process quickly and accurately. Contact customer service using the toll-free number on your MotivHealth Insurance Company member identification card if you have any questions, or communicate with the Live Help team on motivhealth.com. We are happy to serve you.

MEMBER INFORMATION

| | | | | | |
|--|--|--|--|--|------------------|
| Patient's Name (Last, First, M.I.) | | Patient's Date of Birth (mm/dd/yyyy) | | Patient's Sex <input type="checkbox"/> Male <input type="checkbox"/> Female | |
| Policyholder's Name (Last, First, M.I.) | | | Patient's Relationship to Policyholder <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent | | |
| Policyholder's Address | | City | State | Zip | Telephone Number |
| Patient's ID Number | | Group Name | | | Group Number |
| Does the patient have coverage from any other health plan including Medicare? <input type="checkbox"/> No. Please skip to Claim Details. <input type="checkbox"/> Yes. Please attach the Explanation of Benefits (EOB) statement from the primary plan with this claim, and complete the following information | | | | | |
| Name of Other Health Plan | | ID/Policy Number of Other Health Plan | Telephone Number of Other Health Plan | | |
| Provider Tax ID | | Diagnosis Codes - (not just description) | | | |
| Provider NPI | | CPT/Procedure Codes | | | |

Note—Breakdown of charges and proof of payment is required.

CLAIM DETAILS

| | | | | | |
|---|--|--------------------------------------|--|------------------------------|--|
| Name of Provider | | Address where services were rendered | | Date of Service (mm/dd/yyyy) | |
| Diagnosis (describe illness and symptoms requiring treatment): | | | | Total Charges | |
| Briefly describe the services(s) you received: | | | | | |
| Have the charges been paid in full? <input type="checkbox"/> No. <input type="checkbox"/> Yes. Please attach proof of payment in full with your itemized bill. | | | | | |
| In what setting were these services performed? <input type="checkbox"/> Inpatient Hospital <input type="checkbox"/> Outpatient Hospital <input type="checkbox"/> Office/Clinic <input type="checkbox"/> Surgery Center <input type="checkbox"/> Skilled Nursing Facility <input type="checkbox"/> Home <input type="checkbox"/> Other | | | | | |
| If applicable, list the contact information of the physician that prescribed/ordered these services: | | | | | |
| Name | | Address | | Telephone Number | |

INTERNATIONAL SERVICES

| | | | | | |
|---|--|--------------------|--|------------------------------|--|
| Is this claim for expenses incurred outside the U.S.A.? <input type="checkbox"/> No. Please skip to Accident/Injury. <input type="checkbox"/> Yes. Please supply an itemized bill and any available medical records when you submit the claim. | | | | | |
| Name of Provider | | Country of Service | | Date of Service (mm/dd/yyyy) | |
| Diagnosis (describe illness and symptoms requiring treatment): | | Total Charges | | Currency Used | |
| Briefly describe the services(s) you received: | | | | | |

ACCIDENT/INJURY

| | | |
|---|------------------------------|--|
| Is this claim due to an accidental injury? <input type="checkbox"/> No. Please skip to Signature. <input type="checkbox"/> Yes. Please complete this section. | Date of Service (mm/dd/yyyy) | Where did the accident occur? <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> School <input type="checkbox"/> Auto <input type="checkbox"/> Other |
| How did the accident happen? | | |
| Description of Injury: | | |
| Please Note: If there is a another party that may be responsible to pay for these services, such as homeowner's or auto insurance, please finish submitting your claim then contact an agent in our Other Party Liability department at (844) 234-4472 to assist you further. | | |

SIGNATURE

| | | |
|---|---|-------------------|
| To be accepted, this form must be fully completed (as appropriate to the claim being submitted) signed, and have an itemized bill attached. | | |
| Patient's Signature (or legal guardian if patient cannot legally consent to services) | Relationship to Patient <input type="checkbox"/> Self <input type="checkbox"/> Other | Date (mm/dd/yyyy) |
| Please Note: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefit. | | |

I certify that the above statements are correct and hereby authorize any physician, hospital, employer, union, insurance company, or prepayment organization to supply my employer and its agents any information required in connection with this claim. A photocopy of this authorization shall be as valid as the original.

 Signature (Subscriber or Patient)

 Date

Thank you for choosing MotivHealth Insurance Company as your health plan administrator. We recommend that you make copies of everything that is submitted for your personal records.

Mail this claim to:
 MotivHealth Insurance Company
 P.O. Box 709718
 Sandy, UT 84070-9718
 (844) 234-4472

INSTRUCTIONS FOR FILING A CLAIM

IMPORTANT:

- You only need to fill out this form if your health care professional isn't filing the claim for you. Your health care professional can still file the claim for you if they are out-of-network with your policy, however, they are not required to do so.
- Payment is made directly to contracting health care professionals. We only send payment to you when the health care professional is out of network and there is evidence that you have paid in full for the services rendered.
- If services are a result of an accident or injury, complete the Accident/Injury section of the claim form. If there is another party that may be responsible to pay for these services, such as homeowner's or auto insurance, please call us at 844-234-4472 to assist you further.
- If you have Medicare or other insurance coverage that is not already on file with MotivHealth Insurance Company, or if it has changed or terminated, please call us at 844-234-4472 to update your account to ensure your claim processes correctly and timely.

FILING RECOMMENDATIONS:

- Complete a separate claim form for each covered family member.
- Enclose itemized receipts and make copies for your records. It is helpful for receipts to include:
 - Patient's Name
 - Date of Service (mm/dd/yyyy)
 - Procedure Code(s)
 - Diagnosis Code(s) – ICD Format
 - Health care professional's Full Name, Credentials, Address, Phone Number and Tax ID Number and National Provider Identifier (NPI), Total charge for each service rendered
- If the patient has Medicare or other health insurance coverage, and that other insurance coverage is primary and MotivHealth is secondary, we need an Explanation of Benefits (EOB) for this service from the other insurance company when you send the completed form and itemized bill.