Claim Reimbursement Request

Instructions for Completing this Form and Submitting Your Claim

MVP Health Care® is dedicated to prompt and accurate payment of claims to our plan participants. Following these instructions and completing the claim form in its entirety will help us process your claim in a timely manner. Claims submitted without complete documentation cannot be processed and will be returned to you.

Who should complete this form?

MVP members requesting reimbursement for out-of-pocket medical or dental expenses that exceeded their plan co-pay or co-insurance for charges that were more than their plan co-pay or co-insurance.

Submit the required documentation.

Submit a separate reimbursement request for each bill. Include itemized receipts showing your proof of payment and original bills from providers. Keep copies for your records. Cash register receipts, canceled checks, money orders, credit card vouchers, or personal lists of services or bills stating only "balance forward" are not acceptable as substitutes for original bills.

To ensure prompt processing of your claim, bills submitted must include the following (contact your provider to obtain any additional information):

- The name and address of the provider (on letterhead) of the service or supply (e.g., doctor or hospital), including the Tax ID and NPI numbers
- The patient's full name and health plan identification number
- HCPCS or CPT Code(s) for the type of service provided (e.g., office visit, chest x-ray)
- Place of service (e.g., inpatient or outpatient hospital, office)
- Date and charge for each service or supply provided
- ICD-CM code for the medical condition for which the patient was treated (e.g., routine exam, cough, hypertension)

If another insurance carrier has made payment on this service, an explanation of benefits from that carrier must be submitted with the claim.

How to submit your completed claim.

Submit your completed claim and all documentation to MVP by:

- **Mail** to CLAIMS SUBMISSION, MVP HEALTH CARE, PO BOX 2207, SCHENECTADY NY 12301-2207
- **Email** to **submitclaims@mvphealthcare.com**
- **Fax** to **518-395-1395**
- **Online** at **mvphealthcare.com**. *Sign In* to your online account and select *Medical Claim Reimbursement*. Only medical claims can be submitted online. MVP members must be at least 18 years of age to submit a claim online.

If you are not a Medicare plan member, be sure to submit ***both*** pages of the claim form.

Questions? We're here to help!

Call the MVP Customer Care Center at the phone number on the back of your MVP Member ID card.

Claim Reimbursement Request

Section 1: Patient and Subscriber Information *(please print)*

Patient Name *(first, middle initial, last)* | **Patient** Date of Birth | MVP Member ID No.

MVP Subscriber Name *(first, middle initial, last)* | Phone No. ( )

MVP Subscriber Street Address | City | State | Zip Code

Group Name | **Group** No. *(if applicable)*

Section 2: Provider and Billing Information *(contact your provider for the following)*

Provider Name | Phone No. ( ) | Date of Service

Provider Street Address | City | State | Zip Code

Tax ID No. | NPI No.

Type of Service Performed ☐ **Medical** ☐ **Dental** Total Reimbursement Requested ▶ $

Are you covered under another insurance plan that provides coverage for the type of service being submitted? ☐ **Yes** ☐ **No**

If ***Yes***, provide the following information about that insurance:

Insurance Company Name | **Policyholder** Name

Policy or ID No. | Other Carrier Phone No. ( ) | Policy/Other Carrier Effective Date

Insurance Company Street Address | City | State | Zip Code

Section 3: Certification and Authorization to Release

By signing below, I certify that the above statements are correct. I understand that any person who knowingly and with intent to defraud any insurance company or other person, files an application or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and shall be subject to a civil penalty not to exceed $5,000 and the stated value of the claim for each such violation.

Subscriber's Signature *Date*

Non-Medicare Members Only: Please read and sign the **Assignment** and **Release** on page 2.

Non-Medicare Members Only: Please read and sign the **Assignment** and **Release** below.

Assignment. I hereby authorize payment to the hospital, physician, or dentist herein named. I understand I am financially responsible for charges not covered by this assignment.

Subscriber's Signature *Date*

Authorization to Release. I hereby authorize MVP to release or obtain any information which may be necessary to administer this Group Plan. A photocopy of this authorization shall be valid.

Subscriber's Signature *Date*

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*Patient's Signature** *Date*

**Parent should sign for a minor child.*