Claim Reimbursement Request

Instructions for Completing this Form and Submitting Your Claim

Who should complete this form?

MVP members who have paid for medical or dental expenses out-of-pocket and are requesting reimbursement.

Submit the required documentation.

Submit a separate reimbursement request for each bill, and include itemized receipts from providers and copies of your proof of payment.

To ensure prompt processing of your claim, submit only original bills, keep copies for your records. Bills submitted must include:

- 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)

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**.

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

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*. You may submit **medical** only claims online. Only current MVP members age 18 and older my submit medical claims 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.

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MVP HEALTH CARE

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

Patient Name *(first, middle initial, last)* | **Patient** Date of Birth

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

MVP Subscriber Street Address | City | State | Zip Code

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

Section 2: Provider and Billing Information

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

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

Insurance Company Street Address | City | State | Zip Code

Policyholder Name

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*

*Patient's Signature** *Date*

**Parent should sign for a minor child.*