Harvard Pilgrim
POS Plan
P.O. Box 699183
Quincy, MA 02269
1-888-333-4742

CLAIM FORM

TO THE MEMBER

1. Please read and complete this side of the claim form.
2. Please ask your provider to read and complete the back side of the claim form or they may attach a complete and itemized bill.
3. **PLEASE SIGN ONLY ONE OF THE "ASSIGNMENT OF BENEFITS" BOXES.**
4. In states other than Massachusetts and Maine, Allianz Life is the Underwriter of out-of-network benefits for fully insured accounts.

SUBSCRIBER NAME	FIRST	INITIAL	LAST

ADDRESS (STREET AND NO.)	CITY	STATE	ZIP

PATIENT'S NAME	FIRST	INITIAL	LAST

MEMBER IDENTIFICATION NO. (FROM I.D. CARD)	DATE OF BIRTH	SEX
___ ___ ___ ___ ___ ___ ___ ___ ___–___ ___	/ /	M ☐ F ☐

IS THE CONDITION REQUIRING TREATMENT RELATED TO: EMPLOYMENT	☐ YES ☐ NO	AUTO ACCIDENT	☐ YES ☐ NO	INJURY	☐ YES ☐ NO

DATE OF ILLNESS OR ACCIDENT MONTH / DAY / YEAR

HOW AND WHERE DID ACCIDENT OCCUR?

IS THE SUBSCRIBER'S SPOUSE EMPLOYED?	☐ YES ☐ NO	IF YES, NAME OF COMPANY	
IS PATIENT COVERED BY OTHER HEALTH INSURANCE?	☐ YES ☐ NO	IF YES, NAME OF OTHER INSURANCE	ID NUMBER
IS PATIENT COVERED BY OTHER DENTAL INSURANCE?	☐ YES ☐ NO	IF YES, NAME OF OTHER INSURANCE	ID NUMBER

I hereby apply for benefits and certify that the above information is complete, true and correct. To all physicians and other medical professionals, hospitals, and other medical care institutions, and to insurers, medical or hospital service and prepaid health plans, employers and group policy holders, contract holders or benefit plan administrators: You are authorized to provide the Plan and any benefit plan administrators from consumer reporting agencies, attorneys and independent claim administrators acting on the Plan's behalf, with information concerning medical care, advice, treatment or supplies provided to the Patient, and any employment related information regarding the Patient. This information will be used for the purpose of evaluating and administering claims for benefits. I understand that the duration of the authorization is for the term of coverage of the policy or contract under which a claim for health benefits has been submitted. I understand that I have a right to receive a copy of this authorization upon request. I agree that a photographic copy of this authorization is as valid as the original.

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

CLAIM CANNOT BE PROCESSED WITHOUT MEMBER'S SIGNATURE.

SUBSCRIBER'S SIGNATURE DATE

DEPENDENT PATIENT'S SIGNATURE IF NOT A MINOR DATE

ASSIGNMENT OF BENEFITS

PAYMENT WILL BE MADE DIRECTLY TO THE PROVIDER, IF YOU SIGN BELOW.

I AUTHORIZE PAYMENT OF BENEFITS TO THE PHYSICIAN OR PROVIDER DESCRIBED BELOW OR AS INDICATED ON THE ENCLOSED BILL. I UNDERSTAND THAT I AM FINACIALLY RESPONSIBLE TO THE PROVIDER FOR CHARGES IN EXCESS OF THE PLAN'S PAYMENT SCHEDULE OR CHARGES NOT COVERED BY MY BENEFIT PLAN.

SIGNED (SUBSCRIBER) DATE

OR

PAYMENT WILL BE MADE DIRECTLY TO YOU, IF YOU SIGN BELOW.

I AUTHORIZE REIMBURSEMENT OF BENEFITS TO MYSELF FOR SERVICES DESCRIBED BELOW OR AS INDICATED ON THE ENCLOSED BILL. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE TO THE PROVIDER FOR CHARGES IN EXCESS OF THE PLAN'S PAYMENT SCHEDULE OR CHARGES NOT COVERED BY MY BENEFIT PLAN.

SIGNED (SUBSCRIBER) DATE

PLEASE NOTE: PAYMENT FOR SERVICES RENDERED BY CONTRACTED/IN-NETWORK PROVIDERS WILL BE MADE TO THE PHYSICIAN OR PROVIDER OF SERVICE.

TO THE HOSPITAL – ATTACH FULLY COMPLETED UB-92 BILLING FORM.
OR
ATTACH FULLY ITEMIZED STATEMENT OF CHARGES AND CREDITS.

PHYSICIAN'S/SURGEON'S STATEMENT – COMPLETE FOLLOWING OR ATTACH FULLY COMPLETED HCFA 1500 FORM

PATIENT'S NAME: FIRST	INITIAL	LAST	DATE OF BIRTH

DATE OF	ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (LMP)	DATE FIRST CONSULTED YOU FOR THIS CONDITION	HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS? ☐ YES ☐ NO
DATE PATIENT ABLE TO RETURN TO WORK	DATES OF TOTAL DISABILITY FROM / THROUGH		DATES OF PARTIAL DISABILITY FROM / THROUGH
NAME OF REFERRING PHYSICIAN OR OTHER SOUCE (*e.g. public health agency)*			FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES ADMITTED / DISCHARGED
NAME & ADDRESS OF FACILITY WHERE SERVICES RENDERED (*if other than home or office)*			WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE? ☐ NO ☐ YES ▶ CHARGES

DIAGNOSIS AND CONCURRENT CONDITIONS			
PRIMARY	ICD9-CM CODE	SECONDARY	ICD9-CM CODE

PLACE OF SERVICE (POS)
- 1 – Inpatient Hospital
- 2 – Outpatient Hospital
- 3 – Doctor's Office
- 4 – Patient's Home
- 5 – Day Care Facility
- 6 – Night Care Facility
- 7 – Nursing Home
- 8 – Skilled Nursing Facility
- 9 – Ambulance
- 10 – Other Locations
- 11 – Independent Laboratory
- 12 – Other Medical/Surgical Facility
- 13 – Hospital Emergency Room

SERVICES RENDERED FROM	TO	No. OF SVCS.	POS.	DESCRIBE EACH SERVICE SEPARATELY	PROCEDURE NUMBER	AMOUNT BILLED	DO NOT USE THESE SPACES A	AA	O	R

SIGNATURE OF PHYSICIAN OR SUPPLIER	YOUR SOCIAL SECURITY NO.	TOTAL CHARGE	AMOUNT PAID	BALANCE DUE
SIGNED _____ DATE _____				
YOUR PATIENT'S ACCOUNT NO.	YOUR EMPLOYER I.D. NO.	PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE & TELEPHONE NO. I.D. NO.		

AUTHORIZATIONS TO ASSIGN BENEFITS WILL NOT BE HONORED UNLESS YOUR TAX IDENTIFICATION OR SOCIAL SECURITY NUMBER IS SHOWN.

*PLACE OF SERVICE CODES
1 – (IH) – INPATIENT HOSPITAL
2 – (OH) – OUTPATIENT HOSPITAL
3 – (O) – DOCTOR'S OFFICE
4 – (H) – PATIENT'S HOME
5 – DAY CARE FACILITY (PSY)
6 – NIGHT CARE FACILTY (PSY)
7 – (NH) – NURSING HOME
8 – (SNF) – SKILLED NURSING FACILITY
9 – AMBULANCE
O – (OL) – OTHER LOCATIONS
A – (IL) – INDEPENDENT LABORATORY
B – OTHER MEDICAL/SURGICAL FACILITY