Subscriber Reimbursement Medical Claim Form

General instructions:

- Fill out the form completely. Items left blank may prevent or delay in processing of your claim.
- Write your GHC-SCW member ID number on all paperwork you submit.
- Claims must be filed within twelve (12) months from the date of service or they will be denied.
- Attach proof of payment. Examples: cash receipt, credit card statement, copy of cancelled check.
- Keep a copy of the itemized bill or receipt for your records.
- Each form is only for one patient and one provider.
- Do not submit a form if your physician or other health care professional is also filing a claim to GHC-SCW for the same service.

Patient Information:

/ /

Last name | First name | MI | Member ID# | Patient birth date (mm/dd/yy)

Street address | City | State | Zip

( )

Subscriber name (if different from patient) | Subscriber Member ID# | Phone

Provider Information:

( )

Servicing Provider name | Clinic/Facility name | Phone

Provider NPI | Provider Tax ID Number | Provider Credentials

Street address | City | State | Zip

Service Information: (Ask your provider(s) to help you complete all information)

Date (mm/dd/yy)	Place of Service	Codes for procedures, services, or supplies	Diagnosis Code	Number of units	Charges
/ /					
/ /					
/ /					
/ /					
/ /					
/ /					
				Total Charges	

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Type of Treatment Received:

Check only one type and attach itemized statements.
Please use a separate claim form for each different type of treatment.

	Month	Day	Year
☐ Injury – Date of Accident	_______ /	_______ /	_______
☐ Illness – Date of First Symptom	_______ /	_______ /	_______
☐ Pregnancy – Date of Conception	_______ /	_______ /	_______

Type of Treatment Received (continued):

Was Illness or Injury work related? ☐ Yes ☐ No
If an Injury, was a motor vehicle? ☐ Yes ☐ No

Name and address of employer:

____

Medicare – Is the patient:

				Month	Day	Year
a)	Entitled to benefits under Medicare insurance (Part A)	☐ Yes	☐ No	______ /	______ /	______
b)	Entitled to benefits under Medicare insurance (Part B)	☐ Yes	☐ No	______ /	______ /	______
c)	Entitled to benefits due to a disability?	☐ Yes	☐ No	______ /	______ /	______

Patient's Medicare Identification Number (From Medicare ID card):

____

International Claims: (If applicable)

Country Services were provided in: _____________

Currency of claim:

- ☐ MXN (Peso)
- ☐ CAD (Canadian Dollar)
- ☐ EUR (Euro)
- ☐ Other: ___________

If services are not in English, you are required to have documents translated, at your expense, prior to sending them to us. All Inpatient claims must be submitted with translated chart notes.

Clinical Documentation:

It is recommended that members submit clinical documentation for services outside of emergency care.

Group Health Cooperative of South Central Wisconsin may request any additional information deemed necessary to verify services were received and payment was made.

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Member or Authorized Representative Statement:
I attest that the above information is true and accurate and that the services were received and paid for in the amount requested as indicated above. I acknowledge that if any information on this form is misleading, or fraudulent, my coverage may be cancelled and I may be subject to criminal and/or civil penalties for false health care claims. I understand that reimbursement payment will be made to the plan subscriber and will contain information about the service (e.g., provider name, date, description of service). I also understand Group Health Cooperative of South Central Wisconsin may request any additional information it deems necessary to verify that services were received and payment was made.

Signature: ____________________________ **Date:** _____________________

For questions or assistance, you may call our Member Services department at 800-605-4327. If all information has been correctly submitted and no additional documentation is required, you can expect your claim to be processed within 30 days of receipt by GHC-SCW. This is not a guarantee of payment. Actual payment for covered services will be paid at the appropriate level according to your plan benefit.

Documentation Required: Group Health Cooperative of South Central Wisconsin requires proof that the services were rendered and that the member has paid for these services. For GHC-SCW to process your request, you must provide copies of the following:

1. **Provider statement or bill**, showing name of provider and full itemized list of services or items provided.
2. **Customer receipt or statement**, showing payments applied to your account in the form of cash receipt, credit card statement, or cancelled check front and back proving that the member has paid for the services rendered.
3. If you have other primary insurance, a copy of their **statement or EOB** (explanation of benefits) is required.
4. This form must be accompanied with **all receipts and supporting documentation** to be considered for reimbursement.

You may mail your claim to GHC-SCW at the address below:
GHC Claims Department
PO Box 44971
Madison, WI 53744-4971

Or you may fax your claim to us:
(608) 828 – 4856
Attention: Subscriber Reimbursement.

Or you may email your claim to us:
claimsdepartment@ghcscw.com
Subject: Subscriber Reimbursement