Neighborhood Health Plan™

Member Reimbursement Claim Form

Print Form Clear Form

Instructions for Submitting Claims

1. Submit a claim only when you are billed for services from a provider that does not directly submit a claim to NHP.
2. Submit a separate form for each patient.
3. Attach an **original** itemized bill from your provider (required information is on the second page of this form).
4. Keep a copy of all bills and claim forms submitted (originals will not be returned).
5. Be sure to sign and date the completed form.
6. Mail this claim form and all attachments to:

Neighborhood Health Plan
399 Revolution Drive, Suite 940
Somerville, MA 02145

Requested Reimbursement Amount

$

Subscriber (plan holder) Information

NHP Member Number _____ Last Name _____ First Name _____ Middle Initial _____

Address (number and street) _____ City _____ State _____ Zip Code _____

Date of Birth (MM/DD/YY) _____ Employer's Name (if group insurance) _____

Patient Information

Patient Last Name _____ First Name _____ Middle Initial _____ Date of Birth (MM/DD/YY) _____

Gender: ☐ Male ☐ Female

Patient is: ☐ Subscriber (plan holder) ☐ Child/Dependant ☐ Spouse (of plan holder) ☐ Other (specify) _____

Secondary Coverage

Does the patient have other insurance? ☐ Yes ☐ No

Write effective date below

If yes:
- ☐ Medicare Part A (Hospital) _____
- ☐ Medicare Part B (Medical) _____
- ☐ Medicare Part A (Pharmacy) _____
- ☐ Other Insurance Plan _____

Identification number on other insurance plan _____

Name and address of other insurance _____

Was the treatment for...

An accident at work? ☐ Yes, date of accident _____ ☐ No

Auto accident? ☐ Yes, date of accident _____ ☐ No

If yes, name of auto insurance _____

Auto insurance policy number _____

Other accident? ☐ Yes, date of accident _____ ☐ No

I authorize the release of any medical or other information necessary to process this claim.

Subscriber (plan holder) Signature _____ Date _____

Please allow up to 30 days for your claim to process.

Filing Claims

- **You will need to submit an itemized bill that must contain the following required information:**

  1. A letterhead from the provider that MUST include all of the following:
     - Provider name
     - Provider address
     - Provider Tax Identification Number/National Provider Number
     - Provider credentials, i.e., the initials associated with the educational degrees the provider has earned, such as MD.
  2. Patient's name
  3. Date(s) of service
  4. Itemized charges for each date of service and type of service received
  5. Procedure codes (CPT/HCPCS/Revenue codes) for all services received
  6. Diagnosis code(s) for services received
  7. Number of units (this is the number of times a service was performed on a particular date of service)
  8. If the claim is for services received outside of the United States, please include the name of the foreign currency (for example: Euros, Pesos, British Pounds, etc.)

- **Attach any related claim summaries or Explanation of Benefits Forms you may have received for these services, including those received from Medicare or other insurance companies.**

- **When submitting a claim for PRESCRIPTION DRUGS, you must submit an itemized receipt from your pharmacy that includes:**
  - National Drug Code
  - Name of Drug
  - Date dispensed
  - Quantity dispensed
  - Name of prescribing physician

- **Please provide proof of payment (a copy of the canceled check or a receipt that indicates payment was made by the member).**

Claims must be submitted within 12 months of the date of service.