

Kaiser Foundation Health Plan, Inc. California Division

CLAIM FOR EMERGENCY MEDICAL SERVICES

For complete information about your emergency benefits or applicable copayments, deductibles or coinsurance that are your responsibility, please refer to your *Evidence of Coverage booklet*.

Note: If your primary coverage is through another medical plan, you MUST file your claim with that plan first. If there is a balance remaining, after your primary medical plan pays your claim, you may file a claim for Kaiser Foundation Health Plan to pay the difference. Complete the attached Claim for Emergency Medical Services form and mail it along with a copy of your other plan's paid explanation of benefits. Also attach a copy of all related bills. Please refer to your *Evidence of Coverage* for additional information on this process.

Instructions

To request reimbursement for emergency services received at a non-Kaiser Permanente facility:

- 1. Complete both sides of the attached Claim for Emergency Medical Services form.
- 2. Attach additional information, if applicable, that is requested on the back of the Claim for Emergency Medical Services.
- 3. Detach and keep this instruction sheet and make a copy of the Claim for Emergency Medical Services form for your records.
- 4. Date and sign the form.
- 5. Mail your completed form, along with any bills, to one of the following addresses:

For Southern California Members:

Kaiser Foundation Health Plan, Inc. Claims Department P.O. Box 7004 Downey, CA 90242-7004

For Northern California Members:

Kaiser Foundation Health Plan, Inc. Claims Department P.O. Box 12923 Oakland, CA 94604-2923

We will process your claim upon receipt of this completed form. If we need additional information, we will notify you. For information about our time frames for processing your claim, please refer to your *Evidence of Coverage*.

If you have any questions or need assistance, please call our Member Service Call Center at **1-800-390-3510**.



Kaiser Foundation Health Plan, Inc. California Division

MR#:			
Name:			

CLAIM FOR EMERG	ENCY MEDICAL	SERVICES				IMF	PRINT ARE	ĒΑ		
IN ORDER FOR YOUR CLA • BOTH SIDES OF THIS • ALL ITEMIZED BILLS I • THIS FORM MUST BE	FORM MUST BE COMFOR THIS EMERGENC	MPLETED IN FULL. Y MUST BE ATTACHED	. UN	LESS F	CASES, PA' PROOF OF IDER(S).					VIDER(S) HE MEMBER
PATIENT NAME	LAST	FIRST				INIT	SEX	BIRTH D	DATE	
PATIENT ADDRESS	STREET		CITY				STATE	ZIP		
SUBSCRIBER NAME LAST		FIRST		INIT	RELATION TO	PATIENT	(ATIENT D	AY PHON	E
SUBSCRIBER ADDRESS	STREET		CITY				STATE	ZIP	,	
PLACE OF ILLNESS/INJURY	CITY		STATE/COU	INTRY	INCIDENT	DATE		TIME		a.m.
PLACE OF EMERGENCY CARE	CITY		STATE/COU	INITOV	TREATME	NEDATE		TIME		p.m
PLACE OF EMERGENCY CARE	CITY		STATE/COU	INIRI	IREAIME	INIDATE		TIME		☐ a.m. ☐ p.m
IS PATIENT COVERED BY MEDICA Yes No	RE OR OTHER MEDICAL INSU	URANCE?	NAME OF P	OLICY HO	OLDER/SUBSO	CRIBER				
IF YES, INSURANCE COMPANY NA	ME ADDRESS		1	TELEPHONE NO.			SUBSCRIBER ID NO.			
INSURANCE COMPANY NAME	ADDRESS	Т	TELEPHONE NO			SUBSCRIBER ID NO.				
IS MEDICAL COVERAGE PART OF	_		NAME OF P	OLICY H	OLDER					
IF YES, AUTOMOBILE INSURANCE		□ No DDRESS	Т	ELEPHO	NE NO.		POLICY	NO.		
MEMBER'S DESCRIPTION OF HOV	V THE EMERGENCY OCCURF	RED								
WHY WAS THE PATIENT NOT TREA	ATED AT A KAISER PERMANE	NTE FACILITY?								
WAS AN AMBULANCE USED?	WHO CALLED THE AMBU			_						
☐ Yes ☐ No		er Permanente		☐ Oth	ner (specify)				
IF HOSPITALIZED:	ADMIT DATE	DISCHARG	E DATE		IS THE PATIEN		ے م	Yes	□ No	
					RESULT OF T	HE EMERGEI	NCY?	Yes	∐ No	
I authorize		(na	mes of u	provid	ers) to rel	ease anv	and a	II infor	matio	n, including
medical and/or hospita Claim for Emergency M		to the health care s	services	provid	ded to me	on/betw	een th	e dates	s listed	d on this
Plan Inc. to process m						•				

AUTHORIZING SIGNATURE: PARENT'S SIGNATURE IF PATIENT IS A MINOR

DATE SIGNED

CLAIM FOR EM	ERGENCY MEDICAL	SERVICES (Co	ontinued)				
WHEN DID YOU NOTIFY KAISER PERMANENTE? NAME OF YOUR KAISER PERMANENTE DOCTOR			WITH WHOM DID YOU SPEAK? AT WHICH KAISER PERMANENTE MEDICAL OFFICE DO YOU RECEIVE YOUR REGULAR CARE?				
WAS THE INJURY OR ILLNE	SS WORK-RELATED?						
☐ Yes ☐ No		IF YES, PLEASE ATTACH EXPLANATION OF PAYMENT OR DENIAL FROM THE WORKERS' COMPENSATION CARRIER					
WAS THIS INJURY THE RES	ULT OF A MOTOR VEHICLE ACCIDEN	IT?					
			SEND A COPY OF THE DRIVER'S AUTO POLICY FACESHEET IN EFFECT WHEN CCURRED, AS WELL AS A COPY OF YOUR OWN AUTO POLICY FACESHEET.				
WAS THIS INJURY CAUSED	BY SOMEONE ELSE?	IF YES. NAME OF PAR	TY AGAINST WHOM YOU HAVE A CLAII	М	POLICY NUMBER		
☐ Yes ☐ No							
PARTY'S INSURANCE COMP	PANY NAME AND ADDRESS						
If yo	ou have retained an attor	ney, please give	the attorney's name, addr	ess, and	phone number		
ATTORNEY'S NAME		ADDRESS		PHONE NO			
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Attach additional information, if applicable, that is requested on the back of the Claim for Emergency Medical Services, and make a copy of this information for your records. Please submit the following information, if applicable, so that we may process your claim. Please remember to include your name and Medical Record Number on each document.

For all claims:

Itemized bills

Medical records and/or reports that you may have in your possession or to which you have access Receipts of payment

Medical Record Number (that matches the medical record on your ID card)

Additional information required for foreign claims:

Original travel tickets

Original checks

Original receipts of payment

Original bank transfer statements for cash payments