Medical Claim Form
Kaiser Permanente Insurance Company

KAISER PERMANENTE®

IMPORTANT: PLEASE READ THE FOLLOWING BEFORE COMPLETING THIS FORM. PLEASE PRINT IN INK.
Please submit one claim form per patient. All questions must be answered for prompt processing. Attach itemized bills from your hospital, doctor or pharmacy. The bills should include the patient's name, diagnosis, date of service, type of service and charge.
Note: All claims must be filled within one year from the date of service.

SEND THIS COMPLETED CLAIM FOR TO: KAISER PERMANENTE INSURANCE COMPANY (KPIC)
P.O. BOX 30547
SALT LAKE CITY, UT 84130

CUSTOMER SERVICE NUMBER: 1-800-464-4000

EMPLOYEE/RETIREE DATA

NAME OF EMPLOYER	GROUP ID	WORK PHONE ( )	HOME PHONE ( )

EMPLOYEE NAME LAST	FIRST	MIDDLE	SOCIAL SECURITY NUMBER	MEDICAL RECORD #

HOME ADDRESS STREET	CITY	STATE	ZIP-CODE

MARITAL STATUS	OTHER INSURANCE?
__ Single __Married __Divorced __Widowed __ Separated	__ Yes __ No If Yes, complete section below

PATIENT DATA

PATIENT NAME LAST	FIRST	MIDDLE	SEX __ Male __ Female	PHONE NUMBER

DATE OF BIRTH	AGE	DISABLED DEPENDENT __ Yes __ No

RELATIONSHIP TO EMPLOYEE __ Husband __Wife __ Domestic Partner __ Son __ Daughter __ Other (Describe)_____

If this patient is a dependent child, age 18 or older, is he/she a full time student? __ Yes __ No If yes, name of school:_____

Were these charges incurred as a result of an on-the-job illness or injury? __ Yes __ No Other accident __ Yes __ No
If the claim is the result of any kind of accident or injury, complete the following information: Date:_____ Time:_____
Description of what happened:_____

OTHER INSURANCE DATA – PLEASE READ INSTRUCTIONS ON BACK

IS THIS PATIENT EMPLOYED? __ Yes __ No	IF YES, GIVE NAME AND ADDRESS OF EMPLOYER

IS THIS PATIENT OR ANY OTHER FAMILY MEMBER COVERED BY OTHER GROUP HEALTH INSURANCE? __ Yes __ No Complete Section

Name of Insured	Name/Address of Insurance company	ID Number	Group Number

IS THE PATIENT COVERED BY MEDICARE? __ Yes __ No	MAKE PAYMENT TO: __ Me __My Doctor/Hospital __ Other:_____

PLEASE SIGN BELOW TO AUTHORIZE PAYMENT: I understand I am financially responsible for charges not covered by this authorization.
Signature of Patient (Parent, if minor):_____ Date:_____

AUTHORIZATION SIGNATURE FOR INFORMATION RELEASE:
I hereby authorize any insurance company, organization, employer, hospital, physician, surgeon, or pharmacy to release any information requested by Kaiser Permanente Insurance Company. A photocopy of this authorization shall be considered effective and valid as the original.
Signature of Patient (Parent, if minor):_____ Date:_____

PHYSICIAN OR SUPPLIER INFORMATION

HAS UTILIZATION MANAGEMENT BEEN CONTACTED FOR PRECERTIFICATION? __ Yes __ No If yes, Authorization Number:_____

DIAGNOSIS OR NATURE OF ILLNESS OR INJURY: RELATE ITEMS 1, 2, 3 OR 4 TO THE DIAGNOSIS CODE BELOW BY ENTERING THE ITEM NUMBER FOR EACH SERVICE
1._____ 2._____ 3._____ 4._____

DATE(S) OF SERVICE FROM MO | DY | YR	DATE(S) OF SERVICE THROUGH MO | DY | YR	PLACE OF SERVICE	PROCEDURES, SERVICES OR SUPPLIES CPT/HCPCS/ MODIFIER	DIAGNOSIS CODE	FULL DESCRIPTION OF PROCEDURE/SERVICE	DAYS/ UNITS	CHARGE AMOUNT
| |	| |						
| |	| |						
| |	| |						

PROVIDER FEDERAL TAX I.D. NUMBER __SSN __EIN	PATIENT'S ACCT NUMBER	TOTAL CHARGES $	AMT PAID $	BALANCE DUE $

NAME, SIGNATURE, CREDENTIALS OF TREATING PHYSICIAN/SUPPLIER	PROVIDER BILLING NAME, ADDRESS, ZIP CODE AND PHONE#
PRINTED NAME:_____CREDENTIALS_____ SIGNED:_____DATE:_____	

For your protection California law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

HOW TO FILE YOUR CLAIM

1. Answer all questions and sign the "AUTHORIZATION SIGNATURE FOR INFORMATION RELEASE" and "AUTHORIZE PAYMENT" sections on the reverse side of this form.

2. Attached itemized bills/receipts:
   (a) The name of the patient
   (b) Date expense was incurred.
   (c) Nature of encounter (i.e. office visit, xray, etc.)

3. The "PHYSICIAN OR SUPPLIER INFORMATION" section on the reverse side of this form is mandatory for the processing of your request. Your physician/provider may choose to provide you with a printed itemized claim form (CMS-1500) from their billing system for you to submit in lieu of the handwritten section above. Indicate "see attached" and staple the original claims to this form. Keep a copy.

4. File the completed claim form, itemized bills and attachments to:
   KAISER PERMANENTE INSURANCE COMPANY (KPIC)
   P.O. BOX 30547
   SALT LAKE CITY, UT 84130

INSTRUCTIONS FOR COORDINATION OF BENEFITS

If the patient has coverage under any other group insurance plan or government plan, you may be able to receive benefits under both plans and should submit your claim using the following guidelines. This will happen if both you and your spouse or domestic partner (where applicable) work and both of you carry family coverage through your respective employers. In addition to the information you'll need from the other insurance plan described below, be sure to attach a KPIC Medical Claim Form and copies of itemized bills and receipts.

VERSION 3.0
EPO REVISION 08.19.08 CKW
ORIGINAL REVISION 01/03/08 CKW