Independent Health Member Claim Form

For medical claims, mail completed form together with all itemized bills to
Independent Health Claims Department, P.O. Box 9066, Buffalo, NY 14231

For pharmacy claims, mail completed form together with all itemized bills to
Independent Health Attn: Pharmacy Claims, P.O. Box 9066, Buffalo, NY 14231

Member Last Name	First Name	ID No. with **2 digit suffix**	Group No.

Address No. and Street	City	State	Zip Code

Member Date of Birth - MM/DD/YYYY	Patient Relationship to Subscriber ☐ self ☐ spouse ☐ child	Sex ☐ M ☐ F

Were services related to an accidental injury? ☐ YES ☐ NO	If yes, complete ☐ work ☐ auto ☐ motorcycle ☐ other	Date of accident

Name of other insurance company	Policy #

- If the claim is for someone other than you, please submit the **Assignment of Representative (AOR) Form.**
- For services not rendered in the USA, all information must be translated in English.
- Independent Health will reimburse the provider if the provider is participating with Independent Health.

Provider Information (please contact the provider for the following information)

Provider Full Name
Provider Address
Provider Phone #
Provider NPI #
Provider Tax ID # (TIN)
Reason for Visit
Date of Service
Expected Reimbursement

Proof of Payment is Required

☐ check ☐ cash ☐ credit/debit card ☐ money order ☐ wire transfer

Failure to submit **original invoices** will result in a denial of the claim.
Any missing information will cause a delay in processing.

- Original itemized receipts, including all pertinent information, must be submitted with this claim form.
- Itemized bills are required and MUST indicate all of the following information:
  - Member's full name and address on the provider's letterhead
  - Diagnosis or description of illness or injury
  - Type of service or supply that was performed / provided
  - Place of service (e.g., office visit, inpatient hospital, outpatient hospital, emergency room, urgent care, office, laboratory, dental or pharmacy)
  - Date of service
  - Billed charge for each service
  - Total amount paid
- Make copies of the original receipts for your files before submitting

AFFIRMATION: I hereby affirm that the above statements and information on the enclosed bills/receipts are complete and accurate to the best of my knowledge. I also agree to reimburse Independent Health to the extent of any overpayment which is in excess of the amounts payable under my contract/rider(s). In addition, I hereby authorize Independent Health to obtain any information which may be necessary to determine benefits. A photocopy of this authorization will be valid.

Signature _____ Date _____

All claims will be processed according to the terms, conditions and exclusions of your contract.
If you have any questions about this form, please call our Member Services Department at **(716) 631-8701** or **1-800-501-3439**, Monday - Friday, 8 a.m. - 8 p.m.

For Medicare: Call **(716) 250-4401** or **1-800-665-1502** (TTY: **711**), October 1 - March 31: Monday - Sunday, 8 a.m. - 8 p.m.; April 1 - September 30: Monday - Friday, 8 a.m. - 8 p.m.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Independent Health is a Medicare Advantage organization with a Medicare contract offering HMO, HMO-SNP, HMO-POS and PPO plans. Enrollment in Independent Health depends on contract renewal.

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