Independent Health Claim Form

Please fill out claim form completely. In addition to this claim form, you **must** submit proof of payment (such as a receipt) and an itemized bill. Any missing information may cause a delay in processing.

SECTION A – Please complete all of the following:

1. Patient's name: _____

2. IHA ID number with 2-digit suffix: _____

3. Group number: _____

4. Date of birth: _____

5. Address: _____

SECTION B – Please complete all of the following:

6. Name of referring physician or other source: _____

7. Date of service(s): _____

8. Type of visit (check all that apply): _____

_____ Emergency room	_____ Dental	_____ Pharmacy
_____ Outpatient hospital	_____ Inpatient hospital	_____ Other
_____ Ambulance	_____ Office visit	
_____ Laboratory	_____ Urgent care	

9. Provider information

   Provider's full name: _____

   Address: _____

   Phone number: _____

10. Reason for visit and diagnosis: _____

11. Is patient's condition related to: _____

    a. Employment? (Current or Previous) Yes No

    b. Auto accident? Yes No

    c. Other accident? Yes No

Continue on back

SECTION C – *For International Claims Only* – Complete all areas:

1. Expected reimbursement: _____

2. Type of currency used *(ex. Canadian dollar)*: _____

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: _____

IMPORTANT

Proof of payment is required in order to be reimbursed for services. Proof of payment includes, but is not limited to, a valid cash register or credit card receipt, a signed document from the provider, or billing history showing a balance due of $0. Please note: If the charges total over $2,000, a copy of the credit card statement or bank statement showing the billed charges also needs to be included with the proof of payment to verify the paid charges.

- **For medical claims, send completed claim form and proof of payment:**

  Independent Health Claims Department
  P.O. Box 9066
  Buffalo, NY 14231

- **For pharmacy claims, send completed claim form and proof of payment to:**

  Independent Health
  Attn: Pharmacy Claims
  P.O. Box 9066
  Buffalo, NY 14231

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 through Friday from 8 a.m. to 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.