Medical Reimbursement Claim Form

P.O. Box 709718
Sandy, UT 84070-9718
Telephone: 844-234-4472

Thank you for choosing MotivHealth Insurance Company for your health care coverage.

Please review the filing instructions located at the end of this form before you begin for helpful information regarding how to complete your claim so that it will process quickly and accurately.

Contact customer service using the toll-free number on your MotivHealth Insurance Company member identification card if you have any questions, or communicate with the Live Help team on motivhealth.com. We are happy to serve you.

MEMBER INFORMATION

Patient's Name (Last, First, M.I.)	Patients Date of Birth (mm/dd/yyyy)	Patient's Sex ☐Male ☐Female
Policyholder's Name (Last, First, M.I.)	Patient's Relationship to Policyholder ☐Self ☐Spouse ☐Dependent	

Policyholder's Address	City	State	Zip	Telephone Number

Patient's ID Number	Group Name	Group Number

Does the patient have coverage from any other health plan including Medicare?

☐ No. Please skip to Claim Details.

☐ Yes. Please attach the Explanation of Benefits (EOB) statement from the primary plan with this claim, and complete the following information

Name of Other Health Plan	ID/Policy Number of Other Health Plan	Telephone Number of Other Health Plan

CLAIM DETAILS

Name of Provider	Address where services were rendered	Date of Service (mm/dd/yyyy)

Diagnosis (describe illness and symptoms requiring treatment):	Total Charges

Briefly describe the services(s) you received:

Have the charges been paid in full?

☐ **No. ☐ Yes. Please attach proof of payment in full with your itemized bill.**

In what setting were these services performed?

☐Inpatient Hospital ☐Outpatient Hospital ☐Office/Clinic ☐Surgery Center
☐Skilled Nursing Facility ☐Home ☐Other

If applicable, list the contact information of the physician that prescribed/ordered these services:

Name	Address	Telephone Number

INTERNATIONAL SERVICES

Is this claim for expenses incurred outside the U.S.A.?

☐ **No. Please skip to Accident/Injury. ☐ Yes. Please supply an itemized bill and any available medical records when you submit the claim.**

Name of Provider	Country of Service	City of Service	Date of Service (mm/dd/yyyy)

Diagnosis (describe illness and symptoms requiring treatment):	Total Charges	Currency Used

Briefly describe the services(s) you received:

ACCIDENT/INJURY

Is this claim due to an accidental injury? ☐No. Please skip to Signature. ☐Yes. Please complete this section.	Date of Service (mm/dd/yyyy)	Where did the accident occur? ☐Home ☐Work ☐School ☐Auto ☐Other
How did the accident happen?		
Description of Injury:		
Please Note: If there is a another party that may be responsible to pay for these services, such as homeowner's or auto insurance, please finish submitting your claim then contact an agent in our Other Party Liability department at 844-234-4472 to assist you further.		

SIGNATURE

To be accepted, this form must be fully completed (as appropriate to the claim being submitted) signed, and have an itemized bill attached.

Patient's Signature (or legal guardian if patient cannot legally consent to services)	Relationship to Patient ☐Self ☐Other	Date (mm/dd/yyyy)
Please Note: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefit.		

I certify that the above statements are correct and hereby authorize any physician, hospital, employer, union, insurance company, or prepayment organization to supply my employer and its agents any information required in connection with this claim. A photocopy of this authorization shall be as valid as the original.

Signature (Subscriber or Patient) **Date**

Thank you for choosing MotivHealth Insurance Company as your health plan administrator. We recommend that you make copies of everything that is submitted for your personal records.

Mail this claim to:
MotivHealth Insurance Company
P.O. Box 709718
Sandy, UT 84070-9718
Telephone: 844-234-4472

INSTRUCTIONS FOR FILING A CLAIM

IMPORTANT:

- You only need to fill out this form if your health care professional isn't filing the claim for you. Your health care professional can still file the claim for you if they are out-of-network with your policy, however, they are not required to do so.

- Payment is made directly to contracting health care professionals. We only send payment to you when the health care professional is out of network and there is evidence that you have paid in full for the services rendered.

- If services are a result of an accident or injury, complete the Accident/Injury section of the claim form. If there is another party that may be responsible to pay for these services, such as homeowner's or auto insurance, please call us at 844-234-4472 to assist you further.

- If you have Medicare or other insurance coverage that is not already on file with MotivHealth Insurance Company, or if it has changed or terminated, please call us at 844-234-4472 to update your account to ensure your claim processes correctly and timely.

FILING RECOMMENDATIONS:

- Complete a separate claim form for each covered family member.
- Enclose itemized receipts and make copies for your records. It is helpful for receipts to include:
  - Patient's Name
  - Date of Service (mm/dd/yyyy)
  - Procedure Code(s)
  - Diagnosis Code(s) – ICD Format
  - Health care professional's Full Name, Credentials, Address, Phone Number and Tax ID Number and National Provider Identifier (NPI), Total charge for each service rendered
- If the patient has Medicare or other health insurance coverage, and that other insurance coverage is primary and Regence is secondary, we need an Explanation of Benefits (EOB) for this service from the other insurance company when you send the completed form and itemized bill.