Member Reimbursement Claim Form

Instructions

Within this form, the terms "you" and "your" refer to the member. The terms "we", "our", and "us" refer to Healthcare Management Administrators (HMA), your third-party Health Plan administrator.

Use this form for all medical, dental, and vision services covered by HMA. For prescription claims, contact your pharmacy benefits manager (PBM). You need to fill out this form only 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.

Please include itemized receipt(s) with your completed claim form. Each receipt must include the following, at minimum:

- Patient name
- Date(s) of service
- Healthcare provider's information - full name, credentials, full mailing address, and phone number
- Procedure code(s) - this is usually a five-digit number that describes the services/products provided
- Diagnosis code(s), in ICD format - this is the reason for your healthcare treatment
- Total charge for each service rendered

Note: Providers who are contracted with a PPO Network that is accessible and utilized by your Health Plan are contractually required to bill your Plan and be paid directly by the Plan for services they provide to you. If you have received services from a provider who is in your Plan's PPO Network, we will remit payment to the provider, even if you indicate you want reimbursement to go to you. If you have already paid the provider for your care, you will need to contact them to arrange for a refund, if applicable. Moving forward, be sure to provide your providers with your insurance card so they can bill your Plan directly.

Any questions? We are here to help! Contact Customer Care at 800-869-7093.

Submission Information

Please provide the information in this form to us using one of the methods below (pick any option that works for you)**:**

Electronic Submission Options

✓ **Option 1: DocuSign**:

1. Go to https://www.accesshma.com/news-and-resources/member-forms
2. Click on the DocuSign option under **Member Reimbursement Claim Form**
3. Fill out and submit the form in DocuSign

✓ **Option 2: HMA Member Portal**:

1. Go to https://www.accesshma.com/news-and-resources/member-forms
2. Click on the PDF option under **Member Reimbursement Claim Form**
3. Fill out the form in compatible PDF software like Adobe Reader or Acrobat (it is not recommended to try filling out the form in a web browser or on a mobile device, as the form may not work correctly)
4. Login to the member portal at https://accesshma.com/for-members
5. On the member portal, click on **Manage Claims & Deductibles**, click on **Submit a Claim**, and follow the prompts

Paper Submission Options

✓ **Option 1: Fax** the completed form to: 866-458-5488

✓ **Option 2: Mail** the completed form to:
HMA
Attn: Claims Department
PO Box 85008
Bellevue, WA 98015-5008

HMA

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Patient Information

First Name _____ **Last Name** _____

Mailing Address[1] _____

City _____ **State** Select... **ZIP Code** _____

Phone Number _____ **Member ID Number**[?] _____ **Date of Birth** _____

Group/Employer Name _____ **Group Number**[?] _____

Patient's Relationship to Policyholder ◯ Self ◯ Spouse ◯ Dependent

[?] *This information can be located on your insurance ID card. "Member ID" is also called "Employee ID".*

Other Insurance Information

Does the patient have insurance coverage from any other health plan?

◯ No (skip to next section)

◯ Yes (if you haven't provided us with your other insurance information in the past year, please fill out and submit the **Other Health Insurance Coverage Form** (located at https://www.accesshma.com/news-and-resources/member-forms)

Claim Information

Provider Name _____ **Date(s) of Service** _____ **Total Charges** _____

Address Where Services Were Rendered _____ **Have the Charges Been Paid in Full?** ◯ Yes ◯ No

Diagnosis/Symptoms Requiring Treatment _____

Description of Service(s) You Received _____

Provider's Status[2] ◯ In Network ◯ Out of Network ◯ I Don't Know

Provider's NPI Number (If Known)[3] _____ **Provider's Tax ID Number (If Known)**[4] _____

Accident Information

Is This Claim Due to an Accident? ◯ No (skip to next section) ◯ Yes (fill out this section)

Accident Date _____ **Accident Location** ○ Home ○ Work ○ School ○ Auto ○ Other _____

How Did the Accident Happen? _____

Are You Filing a Claim with Labor & Industries (L&I), Homeowner/Auto Insurance, or Any Other Party? ○ Yes ○ No

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1 If your mailing address has changed, please notify your Human Resources (HR) department so they can update the eligibility information they provide to us.
2 You can look up your provider on https://www.accesshma.com/find-a-provider to find out if they are in network or out of network. Please note that you might not be reimbursed (in full, in part, or at all) by your health plan for out of network services. As such, it is recommended that you always verify your provider is in network.
3 This number is often located on receipts from the provider. National Provider Identifier (NPI) is a unique ten-digit identification number issued to health care providers in the United States by the Centers for Medicare and Medicaid Services (CMS). If you don't know your provider's NPI, we will attempt to look it up. However, please note that your claim might be denied if we are unable to verify your provider.
4 This number is often located on receipts from the provider. Tax Identification Number (TIN) is also known as an Employer Identification Number (EIN). A TIN/EIN is a unique nine-digit identification number issued to an organization by the IRS.

HMA

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Reimbursement Information

Claim Reimbursement Should Go to: ◯ Me (the patient listed above) ◯ The provider listed above

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Attachments

Please be sure to include all relevant material (such as receipts) with your submission. Otherwise, your claim might be delayed or denied.

Signature

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 benefits.

By signing below, I indicate the following:

- I certify that the information I provided on this form is true and complete to the best of my knowledge.
- I expressly authorize any provider of care to provide Healthcare Management Administrators with any records concerning me or any member of my family for whom benefits or services have been claimed.

Printed Name (First and Last)	**Relationship to Patient (If you are the patient, put "Self")**
Signature	**Date**