GOLD KIDNEY HEALTH PLAN

Member Reimbursement Claim Form

Important: Complete a separate Member Reimbursement Claim Form for each member asking for reimbursement for covered services and for each doctor and/or facility.

To avoid processing delays, please include the following information with this form:

- Copy of itemized bill showing all services received. Must include name, address, phone number, tax ID number of doctor and/or facility, date of service and all diagnosis and procedure codes.
- Proof of payment for reimbursement

Mail all documents to: Gold Kidney Health Plan
P.O. Box 14050
Scottsdale, Arizona 85267

Section 1: Member information – *Please complete a separate form for each person who received services.*

Last name:	First name:	MI:
Member ID #:	Date of birth (Mo./Day/Yr.):	
Phone #:	Email address:	
Address:		
City:	State:	ZIP:

Section 2: Other insurance – *Complete if it applies.*

Is the member also covered by other medical insurance at this time? ☐ Yes *(Complete information below.)* ☐ No	
Name of other insurance company:	Policy #:
Subscriber/Member ID #:	Does this member have Medicare coverage? ☐ Yes ☐ No

Section 3: Services received – *If services were received outside the U.S., please complete Section 4 also.*

Name of doctor and/or facility or Provider:	Phone number of doctor and/or facility:	
Address of doctor and/or facility:		
Medical description or nature of illness or injury:	Date of service:	Amount requested to be reimbursed:

MEDICAL INFORMATION AUTHORIZATION AND RELEASE[2]

I hereby authorize any physician, health care practitioner, hospital, clinic, or other medically related facility (as listed above) to furnish to Gold Kidney Health Plan, its agents, designees, or representatives any and all information pertaining to medical treatment for purposes of reviewing, investigating or evaluating applications or claims. I also authorize Gold Kidney Health Plan, its agents, designees, or representatives to disclose to a hospital or health care service plan, insurer or self-insurer any such medical information obtained if such disclosure is necessary to allow the processing of any claim. If my coverage is under a Medicare Advantage Agreement, this authorization also permits disclosure to them to the extent necessary for utilization review or financial audit purposes. This authorization shall become effective immediately and shall remain in effect as long as Gold Kidney Health Plan is asked to process claims under my coverage. A photostatic copy of this authorization shall be considered as effective and valid as the original. I hereby certify that the above statements are correct.

Name of person completing form (please print):	Signature:

Date:	Relationship – description of authority to act on behalf of the member, if applicable:

1"Proof of Payment" includes: a copy of the credit card charge slip or online statement, canceled checks, a bank account statement, cash withdrawal slips, or a cruise ship statement.

Note: Invoices are not acceptable proof of payment.

2You may revoke an authorization at any time in writing, except to the extent that we have already taken action on the information disclosed or if we are permitted by law to use the information to contest a claim or coverage under the plan, as referenced in the Notice of Privacy Practices.

Section 4: Foreign claims questionnaire

IF YOU RECEIVED HEALTH CARE SERVICES WHILE TRAVELING OUTSIDE OF THE UNITED STATES, OR ON A CRUISE IN FOREIGN OR DOMESTIC WATERS, YOU'LL NEED TO COMPLETE THIS SECTION. BE SURE TO ANSWER EVERY QUESTION SO YOUR CLAIM CAN BE PROCESSED QUICKLY. PLEASE PROVIDE ALL AVAILABLE DOCUMENTS FOR SERVICES RECEIVED.

What dates were you traveling out of the country?		
What was the nature of your emergency resulting in medical treatment?		
How long were you ill before you received medical attention?		
Were you admitted into the hospital? ☐ Yes ☐ No	If treated in an Urgent Care as an outpatient, how many times did you see the doctor?	
Name of the hospital, clinic or doctor's office where you received treatment:		Dates of admission:
Address:		
Country:		Phone number:
Name of treating physician:		Phone number:
Did you receive diagnostic tests? ☐ Yes ☐ No	If "Yes," what type?	
Were surgical procedures performed? ☐ Yes ☐ No	If "Yes," what type?	
Was your primary doctor in the U.S. notified? ☐ Yes ☐ No	If "Yes," when?	

Note: Only covered benefits or those deemed medically necessary will be considered for reimbursement.