Catholic Health Initiatives

Imagine better health.℠

Medical Claim Form

Fill out this form **only** if your healthcare provider is not submitting the claim for you. See instructions for completing the form on the back.

Section I: Employee Information

Name of Employer

Employee's Name *(Last, First, MI)* | Date of Birth (MM/DD/YYYY)

Employee's Mailing Address ☐ Check here if this is a new address. | City | State | Zip

Employee's QualChoice ID Number (*on front of your ID card*) | Daytime Phone No.

Section II: Patient Information *Complete this section **ONLY** if patient is not the employee.*

Patient's Name *(Last, First, MI)* | Relationship to Employee ☐ Spouse ☐ Dependent ☐ Other | Date of Birth (MM/DD/YYYY) | Gender ☐ Male ☐ Female

Patient's Address *(if different than employee address)* | City | State | Zip

At the time medical service was provided, was the patient employed: ☐ full time ☐ part time ☐ N/A | If student: ☐ full time ☐ part time ☐ N/A

Section III: Accident/Occupational Claim Information *Complete this section **ONLY** if claim is a result of an accident or occupational (work related) injury.*

Is claim related to employment? ☐ YES ☐ NO
If yes, please file with your worker's compensation carrier first.

Is claim related to auto accident? ☐ YES ☐ NO

Date of Accident or Beginning of Illness (MM/DD/YYYY)

Please describe how the accident or work-related illness/injury occurred. *Use separate sheet if necessary. Attach, sign and date.*

Is a claim or lawsuit being filed against a 3rd party, including an insurance company, in order to recover expenses incurred as a result of this accident or illness?
☐ YES ☐ NO
If yes, name of third party: _____

Did accident/illness occur outside the United States? ☐ YES ☐ NO ***If yes,** all statements must be translated into English.*

Section IV: Dependent/Other Coverage Information *Complete this section **ONLY** only if claim is for a dependent/spouse and/or other coverage is in effect.*

Name of Dependent/Spouse (*Last, First, MI*) | Date of Birth (MM/DD/YYYY) | Is dependent/spouse employed? ☐ YES ☐ NO | If NO, has dependent/spouse been employed during last 12 months? ☐ YES ☐ NO

Name of Health Insurance Company | City | State | Zip | Policy Number | Eff. Date of Covg.

Is the dependent/spouse covered under any other health insurance plan or Medicare? ☐ YES ☐ NO
*If **YES**, please send a copy of the Explanation of Benefits (EOB) and the itemized bills with this form.*

Section V: Payment Instructions

By signing below, I affirm in writing that I have not assigned benefits to my healthcare provider. I certify the above is complete and accurate and authorize payment to be made directly to the healthcare provider(s) indicated on the enclosed bill(s).

Employee Signature (Required) | Date (MM/DD/YYYY)

X _____

IMPORTANT INFORMATION

1. We pay covered claims directly to any contracted in-network healthcare provider. If you have already paid for these services, please seek reimbursement from your healthcare provider.
2. The information provided on this form may be disclosed to other persons or entities, including plan sponsors, for the purpose of processing this claim and performing health plan administration.
3. Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit is guilty of a crime and may be subject to fines and confinement in prison.

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Medical Claim Form

Instructions for completing the form.

1. Determine the type of claim you will be filing. (either A. or B.)

A. Filing a claim for services provided by a physician or other non-facility provider:
You must include an original CMS-1500 *Health Claim Form* issued to you by the physician or the non-facility provider — or you may submit an original itemized bill issued to you by the provider of service.

Itemized bills must contain the following information:

- Date of service and diagnosis
- Employee name and QualChoice ID number
- Patient name and date of birth
- Diagnosis and procedure code(s)
- Provider name and address
- Provider Tax ID Number and National Provider Index (NPI) number (or other medical provider who provided the service)
- Amount charged for each service

B. Filing a claim for services provided by a hospital or other facility:
You must include an original UB-04 form issued to you by the hospital or other facility.

2. An itemized bill must be submitted for your claim to be processed.

The following items are not acceptable documentation: cash register receipts, cancelled checks, money order receipts, handwritten claims, or personal lists. The member must provide original documents.

3. The *Medical Claim Form* cannot be processed without the insured's ID number.

To process your claim we need the insured's QualChoice ID card no. This number is located on the front of the insured's ID card.

4. A separate *Medical Claim Form* must be submitted for each eligible member.

Only one claim form per member is needed regardless of the number of receipts.

5. Your claim may be rejected for the following reasons:

- If any information is missing, altered, or unclear.
- If claim form from the healthcare provider is handwritten.
- If claim form is not accompanied by a UB-04, CMS-1500 or original itemized bill.
- If UB-04 and CMS-1500 claim forms are not submitted on red and white paper (not black & white and no copies).
- If claim is submitted past the required time frame.
- If member has assigned benefits to the healthcare provider.

6. You are encouraged to submit claim(s) within 60 days of the date of service.

Claims must be received by QualChoice within one year of the date of service to be eligible for payment.

7. Be sure to retain a copy of your bills for your record.

WHAT TO SUBMIT:

1. *Medical Claim Form* (completed and signed by insured)
2. If physician or non-facility provider: Include original CMS-1500 *Health Claim Form* (see **A.** above) or original itemized bill.
3. If hospital or other facility: Include original UB-04 form (see **B**. above).

8. Mailing Instructions

Please fax or mail completed form to:

QualChoice
ATTN: Claims Processing
P.O. Box 25610
Little Rock, AR 72221

Fax: 501.228.0135

NOTE:

Your Benefit Summary and Evidence of Coverage (EOC) documents describe covered services under your health plan. Submission of this form does not guarantee reimbursement. For questions, call Customer Service at 501.228.7111 or 800.235.7111, 8:00 a.m. to 5:00 p.m., Central Time, Monday through Friday.

Non-Discrimination and Accessibility Notice

QualChoice complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. QualChoice does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

QualChoice:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Customer Service at (501) 228-7111. If you believe that QualChoice has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

QualChoice Civil Rights Coordinator
QualChoice
P.O. Box 25610
Little Rock, AR 72221-5610
(501) 228-7111
Fax #: 501-707-6729
QCA_COE@qualchoice.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the QualChoice Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-868-1019, 800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Notice of Discrimination Grievance Procedures

It is the policy of QualChoice not to discriminate on the basis of race, color, national origin, sex, age or disability. QualChoice has adopted an internal grievance procedure providing for prompt and equitable resolution of complaints alleging any action prohibited by Section 1557 of the Affordable Care Act (42 U.S.C. 18116) and its implementing regulations at 45 CFR part 92, issued by the U.S. Department of Health and Human Services. Section 1557 prohibits discrimination on the basis of race, color, national origin, sex, age or disability in certain health programs and activities. Section 1557 and its implementing regulations may be examined in the office of the QualChoice Civil Rights Coordinator, who has been designated to coordinate the efforts of QualChoice to comply with Section 1557 (the "Section 1557 Coordinator"):

QualChoice Civil Rights Coordinator
QualChoice
P.O. Box 25610
Little Rock, AR 72221-5610
(501) 228-7111
Fax #: 501-707-6729
QCA_COE@qualchoice.com

Any person who believes someone has been subjected to discrimination on the basis of race, color, national origin, sex, age or disability may file a grievance under this procedure. It is against the law for QualChoice to retaliate against anyone who opposes discrimination, files a grievance, or participates in the investigation of a grievance.

Procedure:

- Grievances must be submitted to the Section 1557 Coordinator within sixty (60) days of the date the person filing the grievance becomes aware of the alleged discriminatory action.
- A complaint must be in writing, containing the name and address of the person filing it. The complaint must state the problem or action alleged to be discriminatory and the remedy or relief sought.
- The Section 1557 Coordinator (or her/his designee) shall conduct an investigation of the complaint. This investigation may be informal, but it will be thorough, affording all interested persons an opportunity to submit evidence relevant to the complaint. The Section 1557 Coordinator will maintain the files and records of QualChoice relating to such grievances. To the extent possible, and in accordance with applicable law, the Section 1557 Coordinator will take appropriate steps to preserve the confidentiality of files and records relating to grievances and will share them only with those who have a need to know.
- The Section 1557 Coordinator will issue a written decision on the grievance, based on a preponderance of the evidence, no later than thirty (30) days after its filing, including a notice to the complainant of their right to pursue further administrative or legal remedies.
- The person filing the grievance may appeal the decision of the Section 1557 Coordinator by writing to the Vice President Corporate Responsibility within fifteen (15) days of receiving the Section 1557 Coordinator's decision. The Vice President Corporate Responsibility shall issue a written decision in response to the appeal no later than thirty (30) days after its filing.

The availability and use of this grievance procedure does not prevent a person from pursuing other legal or administrative remedies, including filing a complaint of discrimination on the basis of race, color, national origin, sex, age or disability in court or with the U.S. Department of Health and Human Services, Office for Civil Rights. A person can file a complaint of discrimination electronically through the Office for Civil Rights Complaint Portal, which is available at: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf , or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201.

Complaint forms are available at: http://www.hhs.gov/ocr/office/file/index.html. Such complaints must be filed within 180 days of the date of the alleged discrimination. QualChoice will make appropriate arrangements to ensure that individuals with disabilities and individuals with limited English proficiency are provided auxiliary aids and services or language assistance services, respectively, if needed to participate in this grievance process. Such arrangements may include, but are not limited to, providing qualified interpreters, providing taped cassettes of material for individuals with low vision, or assuring a barrier-free location for the proceedings. The Section 1557 Coordinator will be responsible for such arrangements.

QualChoice offers help for members with limited English proficiency (LEP). The following statement is printed in the top languages used in Arkansas, as required by the Federal government. ***ATTENTION: If you speak [insert language], language assistance services, free of charge, are available to you. Call 1-800-235-7111 (TTY: 711).***

Spanish
ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-235-7111 (TTY: 711).

Vietnamese
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-235-7111 (TTY: 711).

Marshallese
LALE: Ñe kwōj kōnono Kajin Ṃajōḷ, kwomaroñ bōk jerbal in jipañ ilo kajin ṇe aṃ ejjeḷọk wōṇāān. Kaalọk 1-800-235-7111 (TTY: 711).

Chinese
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-235-7111 (TTY: 711).

Lao
ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-800-235-7111 (TTY: 711).

Tagalog
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-235-7111 (TTY: 711).

Arabic
ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-532-1117 (رقمهاتف الصم والبكم: 117).

German
ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-235-7111 (TTY: 711).

French
ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-235-7111 (ATS: 711).

Hmong
LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-800-235-7111 (TTY: 711).

Korean
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-235-7111 (TTY: 711) 번으로 전화해 주십시오.

Portuguese
ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-800-235-7111 (TTY: 711).

Japanese
注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-235-7111 (TTY: 711) まで、お電話にてご連絡ください。

Hindi
ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-800-235-7111 (TTY: 711) पर कॉल करें।

Gujarati
સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-800-235-7111 (TTY: 711).