KAISER PERMANENTE®

Member Reimbursement Form

- **If you have not paid the provider, DO NOT USE THIS FORM. Ask the provider to bill us directly using a CMS 1500 or UB-04 claim form.**
- **Make sure the provider has your Kaiser Permanente membership information.**
- **If you have a claim for outpatient prescription drugs covered by Medi-Cal Rx, DO NOT USE THIS FORM. Please contact the Medi-Cal Rx Customer Service Center (CSC) at (800) 977-2273, 24 hours a day, 7 days a week. TTY users can call 711, Monday through Friday, 8 a.m. to 5 p.m.**
- **Reimbursement requests cannot be combined. Submit a form for each individual reimbursement.**

Instructions:

- Fill out this form to request reimbursement for amounts you PAID the provider.
- Fill out the form completely and sign it. Send all required documents. Incomplete or unsigned forms will be returned to you.
- If you are filling out the form on behalf of someone else, please attach either a Power of Attorney Form or Authorization of Representation Form. (Parents do not need to submit these additional forms if signing on behalf of minor children or legal dependents.)
- Keep a copy of this form and all documents for your records.
- For questions or help with this form, please call Member Services at the number listed on page 3.
- If you are seeking reimbursement for a COVID-19 home antigen test, please fill out the fourth page of this document. If you are not seeking reimbursement for a COVID-19 home antigen test, you can skip all questions on page four.

SECTION A: Patient information

Last Name

First Name **MI**

Home Address

City **State** **ZIP**

Mailing Address ☐ **Check if the same as the home address**

City **State** **ZIP**

Date of Birth (mm/dd/yyyy) **Medical Record Number/Health Record Number (found on ID card)**

SECTION B: Explanation of treatment (optional)

Please describe the services you received. Explain why treatment was not done at Kaiser Permanente.

Was the patient admitted to the hospital?

☐ **Yes** ☐ **No**

If "YES" - Admit Date (mm/dd/yyyy)

☐☐/☐☐/☐☐☐☐

If "YES" - Discharge Date (mm/dd/yyyy)

☐☐/☐☐/☐☐☐☐

Besides the amount you already paid, is the provider expecting additional payment?

☐ **Yes** ☐ **No** ☐ **Unsure**

SECTION C: Required information for reimbursement

To prevent processing delays, you MUST provide the following information:

1. **Proof of Payment:** We need proof you paid the provider. Send us your receipt, bank statement, copies of original checks (front and back), or any other documents showing how much you paid the provider; AND
2. **Provider's Bill:** Send us a copy of the provider's bill you paid. Please include all pages and any detailed billing statements. If you do not have a copy of the bill, please provide the following information:

Name of Patient and medical record number	
Dates of service	
Name of provider (doctor, hospital, ambulance service, pharmacy, laboratory, etc.)	
Address where service was provided (hospital address, doctor address, etc.)	
Services provided to you (X-ray, office visit, injection, etc.) If a prescription, name of drug	
Amount billed	

Note: All documents and information submitted must be legible or the form will be returned.

SECTION D: Cruise or foreign travel reimbursement required documentation

Was the service provided during a cruise or foreign travel? ☐ Yes ☐ No; If "NO" please skip. If "YES", please provide the following information.

- ☐ **Proof of travel: Travel documents; such as a copy of airline tickets or a travel itinerary (optional)**
- ☐ **Copies of original, detailed bills or service (doctor, hospital, and prescriptions)**
- ☐ **Any related medical records, including copies of medical reports, hospital admission notes, emergency room notes, etc.**
- ☐ **Proof of payment for services received, including prescriptions (receipt or bank statement, copies of front and back of checks, or any other documents showing how much you paid the provider)**

Note: All documents and information submitted must be legible or the form will be returned.

Patient Signature

I certify that the information provided on this form is correct to the best of my knowledge. I authorize the release of all information related to the health care services I received on the dates listed on this form. I understand that this information is necessary to allow Kaiser Foundation health Plan, Inc., to process my claim for payment.

Patient/Authorizing name (parent's name if patient is a minor or legal dependent)

Patient/Authorizing signature (parent's signature if patient is a minor or legal dependent)	**Date signed**

Best contact/telephone number

Reimbursement mailing addresses and Member Services phone numbers

COLORADO
Claim Address
P.O. Box 373150
Denver, CO 80237-9998
Member Services
1-303-338-3800

MD, DC, or VA Claim Address
P.O. Box 371860
Denver, CO 80237-9998
Member Services
1-800-777-7902

NORTHWEST (OR, SW WA)
Claim Address
P.O. Box 370050
Denver, CO 80237-9998
Member Services
1-800-813-2000

GEORGIA
Claim Address
P.O. Box 370010
Denver, CO 80237-9998
Member Services
1-888-865-5813

HAWAII
Claim Address
P.O. Box 378021
Denver, CO 80237-9998
Member Services
1-800-966-5955

WASHINGTON (except SW WA)
KPWA Claim Administration
P.O. Box 30766
Salt Lake City, UT 84130-0766
Member Services
1-800-901-4636

CALIFORNIA - SCAL
Claim Address
P.O. Box 7004
Downey, CA 90242-7004
Member Services
1-800-464-4000

CALIFORNIA - NCAL
Claim Address
P.O. Box 8002
Pleasanton, CA 94588
Member Services
1-800-464-4000

SELF-FUNDED MEMBERS
KPIC Self-Funded Claims Administration
P.O. Box 30547
Salt Lake City, UT 84130-0547
Member Services
1-800-533-1833

COVID-19 HOME ANTIGEN TEST INFORMATION

Please fill out this portion of the member reimbursement form only if you are requesting reimbursement for a COVID-19 home antigen test. If you are requesting reimbursement for something else, you can skip this portion.

- Is this reimbursement for a COVID-19 home antigen test? ☐ **Yes** ☐ **No**
- Tests ordered online must have already shipped (not pending, not in process). Please do not request reimbursement until your tests have shipped. Has your test shipped? ☐ **Yes** ☐ **No**
- Did you purchase the test before 1/15/22? ☐ **Yes** ☐ **No**
  - Yes: If test was purchased before 1/15/22, was the test ordered by a physician or proctored? ☐ **Physican** ☐ **Proctored**
  - No: If test was purchased after 1/15/22, was the test ordered by a physician or proctored? ☐ **Physican** ☐ **Proctored**
- Was the test authorized for emergency use or approved by the FDA? ☐ **Yes** ☐ **No**
- Was the test required by your employer? ☐ **Yes** ☐ **No**
- One box or kit may have multiple tests in it. For example, one box may have two tests in it. How many total tests were purchased? _____
- Have you already taken the test? ☐ **Yes** ☐ **No**
  - If yes, where were the results determined? ☐ **Home** ☐ **Lab**
  - Who took the test? *(Please include their name, MRN, and number of tests they took)*

Please include the following documentation with your request:

- An itemized purchase receipt with test name, date of purchase, price, and number of tests.
- Photo of the QR or UPC bar code, cut out from the testing box.
- If your COVID-19 home antigen test is dated before January 15, include evidence of prescription or provider involvement.

Patient Signature

I certify that my COVID-19 home antigen test(s) were purchased for personal use, is not for employment purposes unless required by applicable state law, has not and will not be reimbursed by another source, and is not for resale.

Patient/Authorizing name (parent's name if patient is a minor or legal dependent)

Patient/Authorizing signature (parent's name if patient is a minor or legal dependent)	**Date signed**

Best contact/telephone number