Medical Claim Reimbursement Request

Mail completed claims to: Claims Submission
MVP Health Care
P.O. Box 2207
Schenectady, NY 12301

- For members who paid out of pocket and are requesting reimbursement for medical services.
- Please attach itemized receipts from medical providers with copies of your proof of payment.
- For instructions on how to fill out this form, please see page 2.
- Questions? Call MVP's Customer Care Center at the phone number on the back of your Member ID card.

MEMBER INFORMATION	
Patient Name:	Date of Birth:
Subscriber Name:	Member ID #:
Group Name: (If applicable)	Group #: (If applicable)
Address:	City/State/Zip:
Phone Number:	

PROVIDER / BILLING INFORMATION	
Provider Name:	
Address:	
Phone:	
Tax ID #:	NPI #:

Do you or any members of your family have other medical insurance? ☐ Yes ☐ No

If Yes:

1. Insurance Company: _____
2. Employer Name and Address: _____
   _____
   _____
3. Policy or ID #: _____

Date of Service:

Total Charges: $

I CERTIFY THAT THE ABOVE STATEMENTS ARE CORRECT	
Subscriber's Signature:	Date:

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and shall be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

NON-MEDICARE MEMBERS: Please see reverse page for additional signature requirements.

NON-MEDICARE MEMBERS: PLEASE SIGN BELOW

ASSIGNMENT: I hereby authorize payment directly to the hospital, physician or dentist herein named. I understand I am financially responsible for charges not covered by this assignment.

Employee Signature:_____ Date Signed: _____

AUTHORIZATION TO RELEASE: I hereby authorize MVP to release or obtain any information which may be necessary to administer this Group Plan. A photocopy of this authorization shall be valid.

Employee Signature: _____ Date Signed: _____

Patient Signature: _____ Date Signed: _____
(Parent should sign for a minor child)

How to Submit Your Claim

You may submit your claim to MVP via mail, email or fax.

- **Mail** completed claim to: Claims Submission
  MVP Health Care
  P.O. Box 2207
  Schenectady, NY 12301
- **Email** completed claim to: **submitclaims@mvphealthcare.com**
- **Fax** completed claim to: **518-395-1395**

For additional claim forms, go to **www.mvphealthcare.com,** select *Documents & Forms* and then *Claims & Reimbursement.*

In order to process your claim promptly, please refer to the following guidelines to ensure that all necessary information is included:

A. A separate claim form must accompany each bill. Original bills must be submitted with your claim form. Keep copies for your own records.
B. Bills must include:
   - Name and address (on letterhead) of the provider of service or supply (hospital, doctor, etc.) including tax ID and NPI Number.
   - Patient's full name and health plan identification number.
   - HCPCS or CPT code for the type of service (office visits, chest x-ray, etc.).
   - Place of service (inpatient or outpatient hospital, office, etc.).
   - Date and charge for each service or supply provided.
   - ICD-CM code for the medical condition for which the patient was treated (routine exam, cough, hypertension, etc.).
C. Cash register receipts, cancelled checks, money orders, credit card vouchers and personal lists of services or bills stating only 'balance forward' are not acceptable as substitutes for bills.
D. If another insurance carrier had made payment on this service, an explanation of benefits from the other insurance carrier must be attached.

MVP Health Care is dedicated to prompt and accurate claim payments to our plan participants. By following these instructions and filling out the claim form completely, you will help us process your claim in a satisfactory manner. Thank you.