KAISER FOUNDATION HEALTH PLAN OF THE MID-ATLANTIC STATES, INC.
PO Box 371860
Denver, CO 80237-9998

CLAIM FOR EMERGENCY MEDICAL SERVICES

PLEASE: Attach all itemized bills associated with this claim. Each bill must include a diagnosis and must be submitted within 90 days of the first date of service. Answer all sections completely. See instructions on the back. ***Be sure to sign and complete release form on reverse side of this sheet.***

☐ IN AREA ☐ OUT OF AREA AREA MEMBER MEDICAL RECORD No.:

PATIENT'S NAME LAST FIRST MI SEX BIRTHDATE

PATIENT'S ADDRESS (STREET, CITY, STATE, ZIP CODE)

SUBSCRIBER'S NAME LAST FIRST MI | RELATION TO PATIENT | PATIENT'S DAY PHONE ( )

SUBSCRIBER'S ADDRESS (STREET, CITY, STATE, ZIP CODE) ☐ CHECK IF NEW ADDRESS

Complete if Patient is covered by medical insurance other than Kaiser Foundation health Plan of the Mid-Atlantic States, Inc.

Is Patient covered under other Health Insurance? ☐ NO ☐ YES If yes, name of other insurance company: Effective Date:

Name of Policy Holder | Policy or Identification Number

Is patient covered under Medicare? ☐ NO ☐ YES If yes, Part A ☐ Part B ☐ Part D ☐ Effective Date:

If the subscriber is married, is the spouse employed? ☐ NO ☐ YES If yes, give the name of the spouse's employer

Is patient actively employed? ☐ NO ☐ YES If yes, name of employer

Was patient's condition due to auto accident? ☐ NO ☐ YES | Any other accident injury? ☐ NO ☐ YES | Work related accident of condition? ☐ NO ☐ YES

If an accident, give the date and time of accident: Was another party at fault? ☐ NO ☐ YES Medical Emergency? ☐ NO ☐ YES

If medical emergeny, give dates symptoms began (mo/day/yr) | Diagnosis at the time of treatment

Was patient hospitalized? ☐ NO ☐ YES If yes, complete the following Name of Hospital

Name and Address of admitting Physician | Admission Date (mo/day/yr) | Discharge Date (mo/day/yr)

Describe how the emergency occurred, including why the patient was not treated at a Kaiser Permanente Facility

What date did you notify Kaiser Permanente? | With whom did you speak? | Advice given

I certify that the information provided on this form is correc tto the best of my knowledge. I authorize the release of any and all information necessary to process this claim including medical and/or hospital records to Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. I hereby assign Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. authorization to bill my/my spouse's primary group insurance carrier for all services provided or arranged by physicians with said plan so long as I am a member of said plan. I understand that this arrangement does not limit my rights to receive reimbursement for serivces I receive from non-plan physicians.

Date Signed_____/_____/_____ Patient's Signature (Parent's Signature if the patient is a minor) X______________________________

I authorize Kaiser Foundation Health Plan of the Mid-Atlantic States, inc. to pay this claim directly to the providers of care X______________________________

Do not write in this space. ☐ A ☐ D ☐ R ☐ I | Date Mailed: | By:

CLAIMS DEPARTMENT

Authorization for Release of Medical Information

I authorize

Name of Hospital, Physician, Institution or Agency

Address

City State Zip

to release to

Claims Unit Resubmission
Kaiser Permanente
PO Box 371860
Denver, CO 80237-9998

the following information (information to be released must be clearly specified):
Date of Treatment:

Please check appropriate box(es) below:

- [ ] Emergency Department Record
- [ ] Discharge Summary
- [ ] Operative Report
- [ ] Other

in regard to:

Name of patient at time of treatment Medical Record No.

Date of birth Pt's day phone number

for the purpose of processing a claims under the Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.

I understand that I may revoke this consent at any time except to the extent that action has been taken based on this authorization. I also understand that this authorization shall remain valid for 12 months if the claim involves property or casualty, or remain valid for the term of my coverage with the Plan if the claim is for an accident and sicness insurance benefit.

I understand that I or my authorized representative may receive a copy of this form.

Signature of patient or responsible person Date

Witness Date

If this release pertains to alcohol or drug abuse information, please note that: This information has been disclosed to you from records whose confidentiality protected by Federal law. Federal regulation (42 C.F.R. Part 2) prohibits you from making further disclosure of it without the specific written consent of the patient to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

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I authorize Kaiser Foundation Health Plan of the Mid-Atlantic States, inc. to pay this claim directly to the providers of care X_______________________________________

Do not write in this space. ☐ A ☐ D ☐ R ☐ I | Date Mailed: | By:

Instructions to Member

All members who receive medical services from non-Kaiser Permanente physicians (either inside or outside the Service Area) and would like Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. (Health Plan) to consider payment for the services rendered are required to complete this form. In doing so, please keep the following in mind:

- *If your claim is for a motor vehicle accident, you must first file with your auto insurance company.*
- *If you have primary coverage with another group medical plan, you must first file with your other insurance carrier. You may file a claim with us for emergency services not covered by your other insurance. Please submit the insurance company's explanation of medical benefits paid with this claim form.*
- Attach ALL ORIGINIAL ITEMIZED doctor and hospital bills and return to the address below. AFTER receiving your claim form AND ALL necessary information, it takes approximately 30 days to process your claim.
- Claims will not be processed unless this Claim for Emergency medical Services is completed in full and filed with Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc., within 90 days after the date of the first service for which payment is requested. FEHB members' claims must be submitted by December 31 of the calendar year following the year in which the expense was incurred.
- If you sign a form assigning payment to the physician or hospital, we will pay them directly. Unassigned and paid claims will be reimbursed to you.

The Emergency Services Benefit

This description of the Emergency Services Benefit is only a summary and does not take the place of or modify the benefit as provided by the actual terms of your current Evidence of Coverage (Policy).

If you are hospitalized, you must notify us within 48 hours after emergency hospital treatment begins (or as soon after as reasonably possible.) This benefit is provided only for emergency treatment required before your condition permits transfer to a Kaiser Permanente facility. Medically necessary special transportation is covered with prior approval from a Kaiser Permanente physician. This benefit applies only to care that is a covered service under your Health Plan Service Agreement.

Limitations on benefits for services received from non-Kaiser Permanente Physicians or Facilities

- We will pay only what we determine to be usual, customary, and reasonable charges for covered services received from non-Kaiser Permanente providers.
- When traveling or living outside the service area normal deliveries (including cesarean section) when a mother has completed 36 weeks gestation are not covered emergencies and will not be covered. (Unexpected premature deliveries occurring outside our Service Area are considered emergencies.)
- Payments under this benefit are also subject to:
    1. Limitations or reductions in the case of other health care coverage programs and
    2. Exclusions, limitations and reductions, as described in your current Evidence of Coverage (Policy).

Services at Non-Kaiser Permanente facilities outside our service area

Benefits are provided for emergency services needed because an unforeseen illness or injury occurs while you are outside our Service Area. Follow-up care and routine care are not covered.

You pay any **copayments** that normally apply to the services you receive.

Services at Non-Kaiser Permanente facilities within our service area

Benefits are provided for immediate care needed because of an unforeseen illness or injury and using a Kaiser Permanente facility would cause a delay that would result in your death, serious disability, or significant jeopardy to your condition or the choice of facility is beyond your control or the control of your immediate family.

You pay any **copayment**s that normally apply to the services you receive.

Please refer to your current Evidence of Coverage (Policy) or contact your Member Services Department if you need additional information.

Reconsideration of a Denied Claim

If a claim is denied, you (or your authorized representative) may appeal the decision by following these steps:

1. File a written request with the Health Plan within 60 days after you receive the denial notice.
2. FEHB members must file a written request within 1 year after you receive the denial notice.
3. State clearly why you believe the claim should have been paid. You may also submit additional written material for consideration.

We will normally reach a decision within 30 days. When we complete the appeals procedures, we will send you a written decision along with our reasons and specific Health Plan provisions used in reaching the decision.

Mid-Atlantic States Claims Department
PO Box 371860
Denver, CO 80237-9998