

# MEDICAL EXPENSE

## Claim Form and Instructions


1. PATIENT INFORMATION											
Member ID	Please enter Member ID as shown on card										
Patient's Name (Given Name, Family Name)				Patient's date of birth				Patient's Gender			
								Male		Female	
Name of Insured Member (Given Name, Family Name)				Insured's date of birth				Patient's Relationship to Insured			
								Self	Spouse		Child
Employer of Insured Member				Insured's current mailing address							
Member Email						Phone					

2. OTHER HEALTH INSURANCE											
Is the patient covered under other health insurance?				Yes		No		If YES, please complete this section			
Name and address of other insurance company						Name of the Policy Holder					
Policy Holder's Date of Birth		Policy or identification number of other coverage				Effective Date		Termination Date			

3. DIAGNOSIS – describe illness, injury or symptoms requiring treatment											
Was patient's treatment due to an accident?				Yes		No		If YES, please describe the accident below including the date it occurred			
Was this a work related accident?				Yes		No		If the accident was caused by someone else, attach a statement describing the accident			

4. CHARGES – use a separate line to list each type of service or provider and attach itemized bills for all services											
Name, City & Country of provider making charge			Diagnosis			Description of service			Dates of Service		Charges

5. PAYMENT DETAILS											
Make payment to the provider			If payment is to be paid to the provider, please ensure bank information is on the provider invoice								
Make payment to Primary Insured			Reimbursement Method:			US Dollar Check			Bank Wire Transfer (complete below)		
<small>When possible, utilizing US bank accounts is recommended to avoid unnecessary fees by the receiving bank. U.S. bank accounts (only) wires will be completed via ACH which generally eliminates or reduces wire transaction fees.</small>											
Account Holder's Name – Must be: Principal Member (Policyholder)						Bank Name					
Bank Address, City, Country						Currency of Reimbursement			Bank 9 digit ABA Number - US Banks		
Bank 8 or 11 digit SWIFT Code - NON-US Banks			Bank Account Number			SORT Code			Bank IBAN		
Intermediary Bank Details (If Applicable)											
Name of Intermediary Bank						Intermediary Bank SWIFT Code			Intermediary Bank Account Number		

6. SIGNATURE											
<small>I certify the above is complete and correct and that I am claiming benefits only for charges incurred by the patient named above. Authorization is hereby given to any provider of service, that participated in any way in the patient's care, to release to GeoBlue and its business associates in any country any medical or other personal information that they deem necessary to provide service or adjudicate this claim, recognizing that applicable law concerning personal information may differ among countries. Please see the back of this form for important information.</small>											
Signature of Insured member or patient										Date	

## FRAUD NOTICE

**Alabama:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution, fines, or confinement in prison, or any combination thereof.

**Alaska:** A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete or misleading information may be prosecuted under state law.

**Arizona:** For your protection Arizona law requires the following statement to appear on this form: Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

**Arkansas, Louisiana, Rhode Island, West Virginia:** Any person who knowingly presents a false or fraudulent claim for payment for a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**California:** For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

**Colorado:** It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

**Delaware:** Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

**District of Columbia:** WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

**Florida:** Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

**Hawaii:** For your protection, Hawaii law requires you be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

**Idaho:** Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement containing any false, incomplete, or misleading information is guilty of a felony.

**Indiana:** Any person who knowingly, and with intent to defraud an insurer, files a statement of claim containing false, incomplete or misleading information commits a felony.

**Kentucky:** Any person who knowingly and with intent to defraud any insurance company or other person files a 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.

**Maine, Tennessee, Virginia, Washington:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

**Maryland:** Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**Minnesota:** A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

**New Hampshire:** Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud as provided in R.S.A. 638.20.

**New Jersey:** Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

**New Mexico:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

**New York:** 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 also be subject to a civil penalty not to exceed \$5,000 and the stated value of the claim for each violation.

**Ohio:** Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

**Oklahoma:** WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

**Pennsylvania:** 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 subjects such person to criminal and civil penalties.

**Texas:** Any person who knowingly presents a false or fraudulent claim for payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

## INSTRUCTIONS FOR FILING A CLAIM

The following steps will assist you in filing claims. **Please note that submitting an incomplete form will result in the delay of processing your claim.**

### For Parts 1 – 4 of the claim form:

- Please submit a separate claim form for each patient
- Please be as descriptive as possible
- Submitted bills must be **itemized** – canceled check, cash register receipts and non-itemized "balance due" statements **cannot be** processed.
- An Itemized bill is a full description of all actual charges and each itemized bill must include:
  - Name and address of provider (doctor, hospital, laboratory, ambulance service, etc.), name of patient, date(s) of service, amount charged for each service described, diagnosis or reason for treatment
- Submitted bills for Prescriptions should include the name of the drug, the quantity dispensed and the dosage.

### To accurately complete Part 5., Payment Details:

- Payments are made to the **Primary Participant/Insured Member on the plan**. Payments cannot be made directly to a dependent or to a third party (other than the medical provider).
- For payments made via wire transfer/ACH, the Primary Participant/ Insured Member must be listed as an account holder on the bank account receiving funds.
- If paying international provider, invoice must include bank information**

## SEND COMPLETE CLAIM FORMS, WRITTEN INQUIRIES AND ADDRESS CHANGES TO ADDRESS BELOW

# GeoBlue

One Radnor Corporate Center, Ste 100, Radnor, PA 19087

**Member Services:** +1.610.254.5304  
1.855.282.3517 (U.S. Toll Free)  
**Claims Submission Fax:** 1.610.482.9623  
**Claims Submission Email:** [claims@geo-blue.com](mailto:claims@geo-blue.com)