KAISER PERMANENTE®

Kaiser Foundation Health Plan, Inc.
California Division

CLAIM FOR EMERGENCY MEDICAL SERVICES

For complete information about your emergency benefit, please refer to your Evidence of Coverage booklet.

Note: If your primary coverage is through another medical plan, you MUST file your claim with that plan first. If there is a balance remaining, you can file a claim with Kaiser Foundation Health Plan, Inc. Complete the attached Claim for Emergency Medical Services form and mail it along with a copy of your other plan's paid explanation of benefits. Also attach a copy of all related bills. Please refer to your Evidence of Coverage for additional information on this process.

Instructions

To request reimbursement for emergency services received at a non-Kaiser Permanente facility:

1. Complete both sides of the attached Claim for Emergency Medical Services form
2. Detach and keep this instruction sheet for your records
3. Date and sign the form
4. Mail your completed form, along with any remaining bills, to one of the following addresses:

For Southern California:

Kaiser Foundation Health Plan, Inc.
Claims Department
P.O. Box 7102
Pasadena, CA 91109-7202

For Northern California:

Kaiser Foundation Health Plan, Inc.
Claims Department
P.O. Box 12923
Oakland, CA 94604-2923

We will process your claim upon receipt of this completed form. If we need additional information, we will notify you. For information about our timeframes for processing your claim, please refer to your Evidence of Coverage.

If you have any questions or need assistance, please call our Member Service Call Center at **1-800-464-4000**.

KAISER PERMANENTE®

Kaiser Foundation Health Plan, Inc.
California Division

Name: _____

MR#: _____

IMPRINT AREA

CLAIM FOR EMERGENCY MEDICAL SERVICES

IN ORDER FOR YOUR CLAIM TO BE CONSIDERED FOR PAYMENT:

- BOTH SIDES OF THIS FORM MUST BE COMPLETED IN FULL.
- ALL ITEMIZED BILLS FOR THIS EMERGENCY MUST BE ATTACHED.
- THIS FORM MUST BE SIGNED BY THE MEMBER.
- IN MOST CASES, PAYMENT WILL BE MADE TO PROVIDER(S) UNLESS PROOF OF PAYMENT IS FURNISHED BY THE MEMBER OR PROVIDER(S).

PATIENT NAME	LAST	FIRST	INIT	SEX	BIRTH DATE

PATIENT ADDRESS	STREET	CITY	STATE	ZIP

SUBSCRIBER NAME	LAST	FIRST	INIT	RELATION TO PATIENT	PATIENT DAY PHONE
					( )

SUBSCRIBER ADDRESS	STREET	CITY	STATE	ZIP

PLACE OF ILLNESS/INJURY	CITY	STATE/COUNTRY	INCIDENT DATE	TIME
				☐ a.m. ☐ p.m

PLACE OF EMERGENCY CARE	CITY	STATE/COUNTRY	TREATMENT DATE	TIME
				☐ a.m. ☐ p.m

IS PATIENT COVERED BY MEDICARE OR OTHER MEDICAL INSURANCE?	NAME OF POLICY HOLDER/SUBSCRIBER
☐ Yes ☐ No	

IF YES, INSURANCE COMPANY NAME	ADDRESS	TELEPHONE NO.	SUBSCRIBER ID NO.

INSURANCE COMPANY NAME	ADDRESS	TELEPHONE NO	SUBSCRIBER ID NO.

IS MEDICAL COVERAGE PART OF THE CAR INSURANCE POLICY?	NAME OF POLICY HOLDER
☐ Yes ☐ No	

IF YES, AUTOMOBILE INSURANCE COMPANY NAME	ADDRESS	TELEPHONE NO.	POLICY NO.

MEMBER'S DESCRIPTION OF HOW THE EMERGENCY OCCURRED

WHY WAS THE PATIENT NOT TREATED AT A KAISER PERMANENTE FACILITY?

WAS AN AMBULANCE USED?	WHO CALLED THE AMBULANCE?
☐ Yes ☐ No	☐ Patient ☐ Kaiser Permanente ☐ Police/Fire ☐ Other (specify) _____

IF HOSPITALIZED:	ADMIT DATE	DISCHARGE DATE	IS THE PATIENT DECEASED? ☐ Yes ☐ No
			DID THE PATIENT DIE AS A RESULT OF THE EMERGENCY? ☐ Yes ☐ No

I CERTIFY THAT THE INFORMATION PROVIDED ON THIS CLAIM FORM IS TRUE AND COMPLETE TO 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, INC.

AUTHORIZING SIGNATURE: PARENT'S SIGNATURE IF PATIENT IS A MINOR	DATE SIGNED

CLAIM FOR EMERGENCY MEDICAL SERVICES (Continued)

WHEN DID YOU NOTIFY KAISER PERMANENTE?	WITH WHOM DID YOU SPEAK?
NAME OF YOUR KAISER PERMANENTE DOCTOR	AT WHICH KAISER PERMANENTE MEDICAL OFFICE DO YOU RECEIVE YOUR REGULAR CARE?

WAS THE INJURY OR ILLNESS WORK-RELATED?

☐ Yes ☐ No

IF YES, PLEASE ATTACH EXPLANATION OF PAYMENT OR DENIAL FROM THE WORKERS' COMPENSATION CARRIER

WAS THIS INJURY THE RESULT OF A MOTOR VEHICLE ACCIDENT?

☐ Yes ☐ No

IF YES, PLEASE SEND A COPY OF THE DRIVER'S AUTO POLICY FACESHEET IN EFFECT WHEN THE ACCIDENT OCCURRED, AS WELL AS A COPY OF YOUR OWN AUTO POLICY FACESHEET.

WAS THIS INJURY CAUSED BY SOMEONE ELSE?	IF YES, NAME OF PARTY AGAINST WHOM YOU HAVE A CLAIM	POLICY NUMBER
☐ Yes ☐ No		

PARTY'S INSURANCE COMPANY NAME AND ADDRESS

If you have retained an attorney, please give the attorney's name, address, and phone number

ATTORNEY'S NAME	ADDRESS	PHONE NO.
		( )