

Member Reimbursement Form for Commercial Medical Claims

ONE FORM PER PATIENT PER PROVIDER

Please print clearly, complete all applicable sections and sign. Please utilize Checklist provided prior to submission to expedite claim review. Check your plan coverage for specific deadlines to submit your claim.

1. Member's Name: (Last) (First) (Middle)			2. Member ID#:	3. Group ID#:
4. Member's Address:			5. Phone Number	6. Date of Birth:
7. Peak Subscriber Name:			8. Peak Subscriber ID Number:	

The following information must be obtained from your provider or included on your itemized statement or bill from your provider. Do not send originals as they will not be returned to you.

9a. Dates of Service	b. Place of Service (Office, ER, Urgent care, Hospital, Clinic, Pharmacy, Ambulance, Home) For injuries due to accident, please provide detail (work/auto/other)	c. Diagnosis Codes (ICD-10)	d. Procedure Codes	e. Amount Charged	f. Amount Paid by member

10. Provider's Name: _____ Provider's Tax ID#: Provider's Billing Address (Physical address required. PO Box not appropriate): _____ Provider's NPI (National Provider ID) for services provided in US. _____	11. Other Insurance information: Is the member covered by another plan? Yes No Name of other insurance company: _____ If the other insurance made a payment, please include Explanation of Benefits
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12. Foreign Service: <i>For services out of the country, please explain where services were rendered (Office, ER, Urgent care, Hospital, Clinic, Pharmacy) and explain nature of injury or illness:</i>
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13. Signature of Member (required): Subscriber should sign for minor claimant. <i>I attest that the information above is true and accurate, and the services were received and paid for in the amount requested as indicated above.</i> Signature: _____ Date: _____
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***Please mail this completed form along with your proof of payment to:**

Peak Health 1085 Van Voorhis Rd, Suite 300 Morgantown, WV 26505

Member Claims must be received by Peak Health within 365 days of the date of service. Claims not received within this time frame are ineligible for benefit payment. Submission of this form does not guarantee reimbursement. For any questions, please contact Member Service at 1-833-5-MYPEAK (1-833-569-7325) or visit www.peakhealth.org. TTY users should call 711.)

To expedite review of your reimbursement request, please utilize the Check List below prior to submission:

- _____ Member Claim Form completed and signed
- _____ Copy of your receipt for payment at the time of service.
- _____ Copy of provider's itemized billing which should include:

Name, Address, and National Provider ID (if in US) of Provider.

Name, Tax ID number, & physical address of Vendor (hospital, lab, ambulance, clinic, etc.)

Patient Name

Date of service

Procedure Codes for services

Itemized charging for services rendered

Final Diagnosis Code(s)

- _____ Does your total dollar paid in Box 9F match your payment receipt?
- _____ Are your copies legible?
- _____ If more than one patient or provider is involved, do you have a Member Claim form for each?