

MEMBER REQUEST FOR REIMBURSEMENT FORM

DMC Care - DMC and Karmanos Employees

PATIENT INFORMATION (To Be Completed by Employee)				EMPLOYEE INFORMATION	
1. PATIENT'S NAME (First, middle initial, & last name)		2. PATIENT'S DATE OF BIRTH		3. EMPLOYEE'S NAME, ADDRESS, & PHONE NO.	
FULL-TIME STUDENT <input type="checkbox"/> YES <input type="checkbox"/> NO (If YES, where)				6. EMPLOYEE'S SOC. SEC. NO.	
4. PATIENT'S ADDRESS (If different from employee)		5. PATIENT'S SEX MALE <input type="checkbox"/> FEMALE <input type="checkbox"/>		8. FACILITY NAME	
9. IS SPOUSE EMPLOYED? <input type="checkbox"/> NO <input type="checkbox"/> YES (If YES, give spouse's employer name & address)		7. PATIENT'S RELATIONSHIP <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER		12. IF AN ACCIDENT DATE ____ 20 ____ AND TIME ____ <input type="checkbox"/> AM <input type="checkbox"/> PM	
10. ARE YOU, YOUR SPOUSE OR YOUR DEPENDENT CHILDREN ENTITLED TO BENEFITS UNDER A. ANY OTHER GROUP HEALTH OR WELFARE PLAN <input type="checkbox"/> YES <input type="checkbox"/> NO B. MEDICARE <input type="checkbox"/> YES <input type="checkbox"/> NO		11. WAS CONDITION RELATED TO A. PATIENT'S EMPLOYMENT <input type="checkbox"/> YES <input type="checkbox"/> NO B. AN ACCIDENT <input type="checkbox"/> YES <input type="checkbox"/> NO		DESCRIPTION (HOW & WHERE) _____	
13. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS REQUEST.				14. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO UNDERSIGNED PHYSICIAN OR SUPPLIER FOR SERVICE BELOW.	
SIGNED _____		DATE _____		SIGNED (EMPLOYEE)	
PHYSICIAN OR SUPPLIER INFORMATION (Complete, fold, and mail)					
15. PATIENT'S NAME (First name, middle initial, last name)					
16. DATE OF ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (LMP) _____		17. DATE FIRST CONSULTED YOU FOR THIS CONDITION _____		18. HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS YES <input type="checkbox"/> NO <input type="checkbox"/>	
19. DATE PATIENT ABLE TO RETURN TO WORK _____		20. DATES OF TOTAL DISABILITY FROM _____ THRU _____		DATES OF PARTIAL DISABILITY FROM _____ THRU _____	
21. NAME OF INITIAL TREATING PHYSICIAN			22. FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES ADMITTED _____ DISCHARGED _____		
23. NAME & ADDRESS OF FACILITY WHERE SERVICES RENDERED (If other than home or office)			24. WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE? YES <input type="checkbox"/> NO <input type="checkbox"/> CHARGES		
25. DIAGNOSIS OR NATURE OF ILLNESS/ INJURY - RELATE DIAGNOSIS TO PROCEDURE IN COLUMN BY REFERENCE TO NUMBERS 1. 2. 3. ETC OR DX CODE 1. 2. 3. 4.					
26. A. DATE OF SERVICE	B. PLACE OF SERVICE*	C. FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN Procedure Code (Identify) _____ (Explain unusual services or circumstances)	D. DIAGNOSIS CODE	E. CHARGES	F.
27. SIGNATURE OF PHYSICIAN OR SUPPLIER		28.		29. TOTAL CHARGE	
SIGNED _____		DATE _____		30. AMOUNT PAID	
32. YOUR PATIENT'S ACCOUNT NO.		33. ENTER TAXPAYER IDENTIFICATION NO. TO BE USED FOR 1099 REPORTING PURPOSES: _____		31. BALANCE DUE	
			34. PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE & TELEPHONE NO.		

***PLACE OF SERVICE**

- | | | |
|-------------------------------|-------------------------------------|------------------------------------|
| 1. (IH) - INPATIENT HOSPITAL | 5. - DAY CARE FACILITY (PSY) | 9. - AMBULANCE |
| 2. (OH) - OUTPATIENT HOSPITAL | 6. - NIGHT CARE FACILITY (PSY) | 0. (OL) - OTHER LOCATIONS |
| 3. (C) - DOCTOR'S OFFICE | 7. (NH) - NURSING HOME | A. (IL) - INDEPENDENT LABORATORY |
| 4. (H) - PATIENT'S HOME | 8. (SNF) - SKILLED NURSING FACILITY | B. - OTHER MEDICAL/SUPPLY FACILITY |

***NOTE TO DOCTOR**

If surgery is suggested, please sign and complete information below:

APPROVED BY AMA COUNCIL ON MEDICAL SERVICES 6-74

Signature _____

Date _____

In my professional opinion, the surgery is elective is not elective and can cannot be performed at the patient's convenience without jeopardizing the patient's life or causing serious impairment to the patient's bodily functions.

THIS FORM CAN BE USED FOR DMC CARE OUT-OF-NETWORK MEDICAL and BH/SA only.

FOR REIMBURSEMENT OF MEDICAL CLAIMS

EMPLOYEES:

1. You must complete this form for each different illness or accident. Fill out the top two sections (PATIENT INFORMATION & EMPLOYEE INFORMATION).
2. Attach an itemized receipt from the out-of-network medical provider.
3. If the out-of-network provider (physician, hospital, physical therapist, etc.) is billing directly, have the provider complete the claim form and return it to DMC CARE Claims Department.
4. Payments for services will be sent to the subscriber unless the provider is billing directly for services.
5. DMC Care Members, please call (800) 543-0161 for further information.

HEALTH CARE PROVIDERS:

1. Complete the bottom portion of the form. Payment will be made directly to you unless your statement shows payment was made by the member. Hospitals use the UB-92 or your standard itemized billing form.
2. Providers can call (800) 543-0161 to verify eligibility, benefits coverage, claim inquiries, or obtain authorization.

MAIL ALL OUT-OF-NETWORK MEDICAL CLAIM FORMS AND ITEMIZED RECEIPTS TO:

DMC CARE CLAIMS DEPARTMENT
P. O. BOX 44290
DETROIT, MI 48244

FOR REIMBURSEMENT OF BEHAVIORAL HEALTH AND SUBSTANCE ABUSE CLAIMS

EMPLOYEES:

1. Fill out the top two sections (PATIENT INFORMATION & EMPLOYEE INFORMATION).
2. Attach an itemized receipt from the out-of-network provider.
3. If the out-of-network provider (physician, hospital, therapist, etc.) is billing directly, have the provider complete the claim form and return it to Value Options.
4. Payment for services will be sent to the subscriber unless the provider is billing directly for services.
5. DMC Care Members, please call (877) 362-2472 (DMC-BHSA) for further information.

HEALTH CARE PROVIDERS:

1. Complete the bottom portion of the form. Payment will be made directly to you unless your statement shows payment was made by the member. Hospitals use the UB-92 or your standard itemized billing form.
2. Providers can call (877) 362-2472 (DMC-BHSA) to verify eligibility, benefits coverage, claim inquiries or obtain authorization.

MAIL ALL BEHAVIORAL HEALTH OR SUBSTANCE ABUSE CLAIMS TO:

VALUE OPTIONS
PO BOX 930321
WIXOM, MI 48393-0321

FOR REIMBURSEMENT OF PRESCRIPTION DRUG CLAIMS

EMPLOYEES

Fill out and mail a Navitus Direct Member Reimbursement (DMR) form.

The DMR form is available on www.dmc-care.org (click on Pharmacy, click on 2010 Pharmacy - Navitus)