HealthPlans
A HARVARD PILGRIM COMPANY

PO Box 5199
Westborough, MA 01581
1-800-532-7575
Fax 508-754-9664
www.healthplansinc.com

SUPPLEMENTAL CLAIM FORM

Instructions

Please complete items 1 through 6 below and attach any receipts, bills or other documents that describe the services that you or your family member has received. Please make sure the attachment contains the provider(s) name and address, date(s) on which the service was performed, a description of the service, the charges, and the amount, if any, that you have already paid.

1. Employee Name: ______________________________

2. Address: ______________________________
Street Address / PO Box

____
Apt# / Suite

____
City State ZIP

____
Daytime Phone Number

3. Member ID#: **HH** __ __ __ __ __ __ __ Group #: **00** __ __ __ __

4. Employer's Name: ______________________________

5. Patient Name: ______________________________

6. Relationship to Employee: ☐ Self ☐ Spouse ☐ Child ☐ Other ____________________

Assignment of Benefits

☐ I have paid this bill. Please reimburse me directly. ☐ I have not paid this bill. Please reimburse the provider of service.

Authorization

I hereby authorize payment of the group benefits payable to me directly or to the provider shown on the attached bill or receipt for the treatment or service described. I understand I may be financially responsible for charges not covered by this assignment.

I also confirm that none of the attached expenses were reimbursed under any other health coverage, including any flexible spending account, health savings account or health reimbursement arrangement.

______________________________ ____________________
Signature of Employee Date

- Please **tape your receipts** to the bottom of this form. **DO NOT staple** anything to this form. It may cause a delay in processing.
- If you require more space, please use a separate piece of paper and be sure to include the patient's name and member ID.
- Receipts for each family member must be on a separate form.