



Medical Claim Reimbursement Form

Valley Health Plan Subscriber (Employee) Information

Subscriber's Name (Last, First, Middle Initial) Social Security Number Medical Record Number

Subscriber's Home Address (Street, City, State, Zip Code)

Subscriber's Date of Birth Subscriber's Home Telephone Number Male Single Divorced Legally separated Female Married Widowed

Do you or the patient have other health insurance coverage, including Medicare, or Medi-Cal? Yes No If YES, give name, address, and policy number of other health insurance coverage:

Patient Information

(If the patient and Subscriber are the same, the below patient information does not have to be completed.)

Patient's Name (Last, First, Middle Initial) Date of Birth Male Single Female Married

Patient's home address (street, city, state, ZIP code) Patient's relationship to employee: Self Spouse Child Other Full time student: Yes No

Claim Information

Nature of Illness/Reason for Services:

If needed, use separate sheet to describe.

Was VHP contacted for Authorization? Yes No

Was the service(s) referred by: PCP Physician Valley Connection Pharmacy Other

Date(s) of Service: Provider of Service: Amount Paid for Service(s): \$

If needed, use separate sheet to list all services provided. Total Amount Paid for All Services: \$

Is this a work injury -Workers Compensation (WC) or caused by an automobile or other type of accident? Yes No If YES, complete the following:

Date of accident: Name of Auto Insurance or Workers Comp Carrier

Auto or Workers Comp Claim # Describe how, when, and where the accident occurred:

Are any of the illnesses or injuries for which this claim is being made related to your job/employer? Yes No

Are you entitled to reimbursement for all or part of these expenses through any other coverage that provides medical benefits or services? Yes No If YES, please provide other coverage information.

Authorization Signature For Release of Information

I hereby authorize any insurance company, organization, employer, hospital, physician, surgeon, or pharmacy to release information requested by Valley Health Plan. A photocopy of the authorization shall be considered as effective and valid as the original.

Subscriber or Patient's signature. For minor children, a parent must sign. Date:

For your protection, California law requires that the following statement be included on this form: Any person who knowingly presents a 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.

If approved, a reimbursement check will be sent payable to the Subscriber at the address on file with VHP or as applicable to Provider within 45 working days.

How To File A Medical Claim Reimbursement Form

Medical Claim Reimbursement Forms must be submitted to Valley Health Plan within ninety (90) days of the date of service.

1. Complete and sign the “Medical Claim Reimbursement Form”.
2. Send the “Medical Claim Reimbursement Form” together with original receipt(s), original itemized bill(s) or invoice(s) from provider, proof of payment and medical records.
 - a) Paid Receipt(s) must include:
 - name of patient, and
 - name of doctor, hospital, prescription/pharmacy, or other provider, and
 - date paid, and
 - amount paid.Other proof of payment, such as copy of cashed check or credit card receipt may be required.
 - b) Each itemized bill(s) or invoice(s) from the provider who provided the services (e.g. physician, hospital) must include:
 - name of patient, and
 - date(s) of service, and
 - nature of illness or injury - including medical or hospital billing code(s).

If in the event of a foreign receipt, payment will be calculated based on dollar conversion rate at the time of service.

3. Mail or walk-in the completed “Medical Claim Reimbursement Form” with bills, invoices, receipts, and medical records to:
 - Attention: Member Services
 - Valley Health Plan
 - 2325 Enborg Lane, Suite 290
 - San Jose, CA 95128