# Claim Submission Form

Claim forms for reimbursement must be submitted no later than ninety (90) days from the date of service or discharge or ninety (90) days from the date the deductible or out-of-pocket maximum is met or thirty (30) days from date of return for Travel Allowance. Claim forms must include all original receipts and all required documentation stated below. All claims will be processed based on eligible charges for Participating Providers and a percentage of eligible charges at Non-Participating Providers. Incomplete requests for reimbursement will not be accepted and StayWell will not request supporting documents from providers.

## CLAIM INFORMATION

### Doctor's Services

☐ Name of Doctor ☐ CMS 1500 claim form ☐ Procedure Code (CPT) ☐ Diagnosis Code (ICD10) ☐ Date of Service
☐ Original Receipt/Proof of payment ☐ Itemized billed charges

### Laboratory

☐ Name of laboratory ☐ Procedure code (CPT) ☐ Name of referring physician ☐ Name of procedure ☐ Date of service
☐ Diagnosis Code (ICD10) ☐ Itemized billed charges ☐ Original Receipt/Proof of payment

### Hospital Services

☐ Patient account no. ☐ UB-04 claim form ☐ Itemized breakdown of total charges
☐ Proof of payment in full ☐ Complete medical report (e.g., daily progress notes, discharge summary)

### Prescription Drugs

☐ Name of pharmacy ☐ Name of prescribing physician ☐ Proof of denial (if purchased from participating pharmacy) ☐ Date of purchase
☐ Proof of payment with drug information ☐ National Drug Code (NDC) ☐ Name and strength of medication ☐ Itemized billed charges

### Travel Allowance

All official receipts and original documents must have claimant's name and must be submitted within 30 days of date of return to place of residence in Guam or the CNMI.

☐ Airfare receipt ☐ Official hotel receipt ☐ Airline boarding pass

| Provider/Pharmacy/Airline/Lodging | Dates | | Paid | Official Use |
|---|---|---|---|---|
| Name | From | Thru | Amount | |
| | | | | |
| | | | | |
| | | | | |

## PAYMENT

| | |
|---|---|
| ☐ Check will be mailed to address on file | ☐ Check will be picked up by member or authorized representative (requires ID) |

## MEMBER INFORMATION

| | | | |
|---|---|---|---|
| A. Member Name | | B. Date of Birth | |
| C. Member ID Number | | D. Dependent No. | |
| E. Mailing Address | | | |
| F. Home Phone | | G. Work Phone | |

| | | |
|---|---|---|
| H1. IS THE PATIENT COVERED UNDER ANOTHER HEALTH INSURANCE PLAN? | ☐ Yes | ☐ No |

| IF YES, PLEASE PROVIDE NAME OF HEALTH INSURANCE COMPANY | EFFECTIVE DATE OF COVERAGE | POLICY NUMBER |
|---|---|---|
| | MM DD YYYY | |

| | | |
|---|---|---|
| H2. IS THE PATIENT COVERED UNDER MEDICARE? | ☐ Yes | ☐ No |

If you answered yes to H1 and/or H2 above, and the other insurance company is primary, then please also submit a copy of the explanation of benefits (EOB) along with your receipt and Claim Submission Form.

## CERTIFICATION

I certify that the information supplied in this form is true, accurate and complete. I acknowledge that this claim form, and all required documentation must be submitted as provided in the above requirements section. The failure to timely submit claim forms will result in expenses not being covered. I understand that all claims will be processed based on eligible charges for Participating Providers and a percentage of eligible charges at Non-Participating Providers. I understand that StayWell has no agreement with Non-Participating Providers and they may charge me more than the eligible charge for any service. I also understand that my claim(s) may be delayed and/or denied if any requirements are not submitted timely or in compliance with the above requirements section. Further, I authorize the release of any protected health information required by StayWell to process my claim(s).

| Member Signature (If member is under the age of 18, parent or guardian must sign) | Date | MM DD YYYY |
|---|---|---|
| | | |

You are responsible for any excess charges over eligible charges. Reimbursements are generally issued within thirty (30) business days from receipt of a completed claim form and supporting documentation. If you submit a bill in a foreign language for services rendered off-island, all required information must be translated into English for you to receive reimbursement.

For assistance, please contact StayWell Customer Care at (671) 477-5091, M-F 8 AM to 5 PM or email customercare@staywellguam.com