Bucknell UNIVERSITY FACULTY AND STAFF HEALTH PLAN

GEISINGER HEALTH PLANS

Medical Claim Reimbursement Form

This form should be used to file medical claims. Please use the separate pharmacy claims reimbursement form for prescription drug claims. You need to fill out this form only if your health care provider isn't filing the claim for you. The member must sign and date each form to be eligible for reimbursement. Completion and submission of this form does not guarantee requested reimbursement.

Step 1 Fill out form completely, providing member and medical claim information. Claims are paid directly to the member if services are rendered by non-participating providers and the services are covered.

Step 2 **Attach your receipt of payment with description of services provided**.

Step 3	**Member Information**		
Member's Name: Last	First		
Subscriber's Name: Last	First		
Insurance ID Number:		Member Date of Birth:	
Street Address:			
City:	State:	Zip:	Telephone:

☐ Check if new address

Has the claim been submitted to an insurance company other than Geisinger Health Plan?

(Please circle) Yes No

Step 4	**Medical Claim Information**
Name of Provider:	Name of Facility:
Provider's Address:	State: Zip:
Diagnosis Code:	Provider's Tax ID#:
Procedure Code:	Date of Service:
Amount Paid for Service:	Total Amount Paid:

Signature_____ Date_____

I certify that the information is correct and that the service listed above is for myself or a member of my family who is eligible. I have received the service described above and authorize release of all information contained on this claim to my plan sponsor (Any person knowingly and with intent to defraud any insurance company or other person files an application for insurance or state of claim containing materially false information or conceals for the purpose of misleading, information concerning any material fact thereto commits a fraudulent insurance act, which is a crime and is subject to criminal and civil penalties).

MAILING INSTRUCTIONS - Send your completed claim form and itemized bill(s) to: Geisinger Health Plan, PO Box 8200, Danville, PA 17821 OR **FAX** TO: 570-214-9366. Please send attention: Claims Department. If you have additional questions, please contact Geisinger Health Options Customer Service at (800) 504-0443.

**Geisinger Health Plans refers collectively to Geisinger Health Plan, Geisinger Quality Options, Inc., and Geisinger Indemnity Insurance Company.*

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