# Member Claim Form
## Medical Services Only

**Do not file prescription drugs on this form. Use blue or black ink to complete.**

- Visit www.healthpartners.com/cityofduluth/ for information regarding your medical benefits or call the toll-free number on your ID card.
- Complete a separate claim form for each covered family member.
- Enclose itemized receipts and make copies for your records.
- Do not file a claim if the provider is filing for the same services.
- Attach the Explanation of Benefits if these services are covered by another insurance policy.
- Claims must be filed within 18 months from the date services were received, or they will be denied.
- Any claim filed without the required documentation requested below will be returned.

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**Section I: Patient Information**

Plan #25077 Subscriber Number: _____

Patient's Last Name: _____ First Name: _____ MI: __

Date of Birth: _____ Gender: ☐ Male ☐ Female

Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

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**Section II: Services and supplies to be considered for reimbursement**
These may include out-of-network services for medical or ambulance services, or durable medical equipment.

**HealthPartners requires that procedure codes and diagnosis codes on the itemized receipt be supplied by the provider of the service. Claims or itemized receipts received without the information below will be RETURNED.**

Indicate where services were provided: _____
Name of Provider, Clinic, Hospital or Facility

_____
Address City State Zip Code

Provider's Tax Identification Number: _____

| Date of Service (MM-DD-YYYY) | Procedure Codes or Description of Service/Supplies | Diagnosis Codes or Symptoms You Sought Treatment For | Charge |
|---|---|---|---|
| Example: 01-05-2011 | Example: Office Visit | Example: Cold & Flu Symptoms | Example: $54.00 |
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**Section III: Mailing Information**

| **Mail this Form, Itemized Receipts and Explanation of Benefits (*if applicable*) TO:**<br>HealthPartners<br>P.O. Box 1289<br>Mpls, MN 55440 | **DID YOU REMEMBER TO:**<br>• Use blue or black ink to complete the form?<br>• Attach itemized receipts?<br>• Attach the Explanation of Benefits, if applicable?<br>• Provide your signature below?<br>• Keep a copy of the form and your receipts? |
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By my signature below, I certify that the information on this form is correct and the expenses incurred were medically necessary for the services filed.

Signed: _____ Date: _____