INDECS
A HOMESTEAD COMPANY

Claims Department, PO Box 21082 • Eagan, MN 55121-0082-0668 • Tel: 888-446-3327 • Fax: 201-460-3204 • www.homesteadplans.com

MEMBER REIMBURSEMENT CLAIM FORM

PART A: MEMBER INFORMATION

Name of Member Member ID #

Address City State Zip Code

Primary Telephone Date of Birth Sex: Male Female

Name of Employer Address City State Zip Code

Active Retired COBRA
Coverage Type

Marital Status: Single Married Divorced Legally separated Widow Member Email Address:____

Do you or your dependent child(ren) or spouse have other health insurance coverage? Yes No

If "yes," name of person covered

Relationship to member: Self Spouse Dependent child

Name of Insurance Plan Policy/Group Number

Insurance Plan Telephone Effective Date of Coverage

PART B: PATIENT INFORMATION

Patient Full Name Patient Date of Birth Sex: Male Female

Patient's relationship to member: Self Spouse Dependent Child Other:

(Please specify)

Is patient a spouse or dependent age 19 or older? Yes No If yes, is spouse or dependent employed? Yes No If yes, Full time Part time

Please give employer name and address:

Employer Name Employer Address City State Zip code

Were services related to an injury: Yes No If yes, give date accident occurred _________________ Is injury related to: Auto Workers Compensation

Other:

(Please specify)

Has legal action been taken, or will it be? Yes No

If yes, give lawyer Name Lawyer Telephone Number

Address City State Zip code

I authorize the release of any medical information necessary to process this claim.

X

Patient Signature **Date**

I authorize payment of medical benefits to the undersigned physician or supplier for the services described in Part C.

X

Member Signature **Date**

PART C: PHYSICIAN OR SUPPLIER INFORMATION – Please have physician or supplier complete all items.

Date of first treatment for condition

Was this an initial consultation? Yes No Preventive care? Yes No Mental Health? Yes No

Is condition due to injury or illness arising out of patient's employment? Yes No

For service related to hospitalization, give hospitalization dates:

Date Admitted Date Discharged

Name of Hospital

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Address of Hospital | City | State | Zip Code

Will any claim for the services reported below be filed with any other insurance carrier? Yes No ____________________
If yes, please specify

Diagnosis or nature of injury or illness (if diagnosis code is other than ICD-10, * give name):

1. Primary | 2. Secondary

*ICD-10 Code

Report of Services (or attach itemized bill):

Date of Services	Place of Services **	Description of Surgical or Medical Services Rendered	Procedure Code (if code other than CPT*** used, give name)	Charges

** DO – Doctor's office H – Inpatient hospital NH – Nursing home

H – Patient's home OH – Outpatient hospital OL – Other location

*ICD-10 – International Classification of Diseases ***CPT – Current Procedural Terminology (current condition)

TOTAL CHARGES $____________

PATIENT PAID AMOUNT $____________

BALANCE DUE $____________

Name of Provider | Specialty

Address | City | State | Zip code

Telephone | Provider Tax Identification (TIN) # | NPI #

X____

Physician Signature **Date**

NOTE: If you are accepting an assignment of benefits, please provide the tax identification of the provider to avoid delay in payment.

PART D: CLAIM FILING INSTRUCTIONS – Follow these directions to avoid delay in payment.

- Member must complete Parts A and B of claim form.
- Have your physician or supplier complete Part C, or
- You may attach an itemized bill with, (1) Name of patient, (2) Date of service, (3) Provider name and Tax ID, (4) ICD code, CPT code, (5) Billed charges for each service and patient paid amount.
- A separate claim form must be completed for each patient.
- If you have insurance that is primary, you must attach a copy of the explanation of benefits from the primary insurance plan.
- The completed form should be sent to INDECS – A Homestead Company using any of the below methods within 30 days of when services were provided.

SUBMIT YOUR CLAIM BY: **Mail:** INDECS Claims Dept, PO Box 21082, Eagan, MN 55121-0082

Fax: 201-460-3204

Online: Member Portal

Email: claims@indecscorp.com