



220 Alexander Street  
 Rochester, NY 14607-4002  
 mvphealthcare.com

# Medical Benefits Request

Mail completed claims to: Claims Submission  
 MVP Health Care  
 P.O. Box 22920  
 Rochester, NY 14692-2920

Health Plan ID#: \_\_\_\_\_

Subscriber's Full Name: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip Code: \_\_\_\_\_

Telephone: (     ) \_\_\_\_\_

**1. Patient Information:**

1a. Patient's Full Name: \_\_\_\_\_

2. Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	3. <input type="checkbox"/> Active Employee <input type="checkbox"/> Retired Date of retirement: _____	4. Patient's Date of Birth: _____	5. If treatment was the result of a non-work injury, give date of injury: _____
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6. If other than USA, in what country was patient treated? \_\_\_\_\_

7. Patient diagnosis: <i>(illness/injury which required treatment)</i> : _____	8. Insured or Authorized Person's Signature: I authorize payment of medical benefits to the undersigned physician or supplier for services described below.  Signature: _____  Check if you want payment made directly to the subscriber. . . . . <input type="checkbox"/>  Payment will be paid directly to servicing provider unless proof of payment is attached (e.g. cash register receipt, cancelled check, money orders, credit card statement).
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9. Medicare: You must complete Section 11 if you are covered by Medicare, regardless of your age. Send bills and matching "Explanation of Medicare Benefit".

10. Motor Vehicle or Work Related Illness or Injury: Check if applicable

the treatment was related to a motor vehicle incident

the treatment resulted from a work related illness or injury

10a. If either box is checked, please describe accident or illness: _____	10b. Date of accident or illness: _____
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11. Other Insurance Carrier: <i>If the patient is covered by another health care plan</i>	If we are your secondary insurance, please be sure to send itemized bill and matching Explanation of Benefit form(s) from the other insurance company.
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11a. Policyholder's Name: _____	11b. Date of Birth: _____	11c. Plan Participant Identification Number: _____
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11d. Name of Policyholder's Employer: _____	11e. Employment Status: <input type="checkbox"/> Active <input type="checkbox"/> Retired	11f. Type of Coverage: <input type="checkbox"/> Hospital <input type="checkbox"/> Surgical <input type="checkbox"/> Vision <input type="checkbox"/> Medical <input type="checkbox"/> Pharmacy <input type="checkbox"/> Dental <input type="checkbox"/> Other
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11g. Policy, Certificate, or Medicare ID#: _____	11h. Medicare Effective/Cancellation Date: Part A: _____ Part B: _____	11i. Carrier's Telephone Number: _____	11j. Spouse's Date of Birth: _____
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12. Acknowledgment and Patient's or Authorized Person's Signature:  
 Patient must sign below or this claim form will be returned without processing. I understand and acknowledge that any person who knowingly and with intent to defraud or mislead any insurance company or other person files a statement of claim containing any materially false information, or conceals information concerning any fact material thereto, commits a fraudulent insurance act and may be subject to criminal and civil penalties, which may not exceed \$5,000 and the stated value of the claim for each violation. I hereby authorize any insurance company, organization, employer, hospital, doctor or any other provider of service to release any medical and other information requested that is necessary to process this claim.

Date: _____	Patient's or Authorized Person's Signature: _____
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To facilitate prompt processing and payment of this claim, you are encouraged to include documentation from the servicing provider detailing why services and supplies are medically necessary. Please note that upon review, we may need to request addition documentation from the servicing provider.

## How To Submit Your Claim

This claim form can be used to submit all your bills. However, a separate claim form must be completed for each person's bills, and a separate claim form must accompany each bill. If you need additional claim forms, please call Member Services at (585) 325-3113 or toll-free (800) 950-3224. TTY users call (585) 325-2629 or toll-free (800) 662-1220.

If you have any questions about completing the claim form or benefits covered under your contract, please contact us at the number listed on your identification card.

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In order to process your claim promptly, please refer to the following guidelines to ensure that all necessary information is included:

- A. Submit bills for each patient on separate claim forms. A separate claim form also is required for different calendar years. A separate claim form must accompany each bill. Original bills must be submitted with your claim form. Keep copies for your own records.
- B. Bills must include:
- Name and address (on letterhead) of the provider of service or supply (hospital, doctor, etc.) including tax ID.
  - Patient's full name and health plan identification number.
  - Type of service or supply (office visits, chest x-ray, etc.), including CPT or HCPCs code.
  - Place of service (inpatient or outpatient hospital, office etc.).
  - Date and charge, for each service or supply provided.
  - Patient's diagnosis codes (the medical condition for which the patient was treated), or ICD•9•CM diagnosis code.
- C. Cash register receipts, cancelled checks, money orders, credit card vouchers and personal lists of services or bills stating only 'balance forward' are not acceptable as substitutes for bills.
- D. If another insurance carrier or Medicare has made payment on this service, an explanation of benefits from the other insurance carrier must be attached.
- E. Payment will be made directly to provider, unless proof of payment is attached, in which case reimbursement will be sent directly to the subscriber.

MVP Health Care is dedicated to prompt and accurate claim payments to our plan participants. By following these instructions and filling out the claim form completely, you will help us process your claim in a satisfactory manner. Thank you.