



**14. Foreign Claims:**

For services out of country, please provide name of country: \_\_\_\_\_

Where services were rendered:  Office/ Clinic     ER     Urgent Care     Hospital     Pharmacy

Please explain injury or illness:

**Itemized bills, receipts, and statements must be translated prior to submittal. Translation will be at the members expense.  
All Inpatient claims must be submitted with translated chart notes.**

**15. I have attached one of the following proof of payments:**

- The front and back of the cleared check written to the provider, or bank encoded copy of the front check written to the provider.
- A copy of a credit card statement that includes the charges and the provider's name.
- A copy of the receipt, with the provider's name and address preprinted on the receipt.

**Note: Itemized statements/ invoices do not count as proof of payment.**

**16. Information about payment(s) made:**

Was there a discount for the services?

- Yes     No

If Yes, is the amount paid after the discount?

- Yes     No

Is there a balance due?

- Yes     No

**Note: If there is a balance due to the provider you may not be entitled to a refund.**

**17. Other Insurance information:**

Is the patient covered by another health plan?     Yes     No

Subscriber name for other insurance:

Name of other insurance company:

Did other insurance make a payment?     Yes     No

**If yes, include Explanation of Benefits from other insurance plan(s).**

**18. Signature is required:**

I attest that the above information is true and accurate, and the services were received and paid for in the amount requested as indicated above. I acknowledge that if any information on this form is misleading or fraudulent, my coverage may be cancelled and I may be subject to criminal and / or civil penalties for false health care claims.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

For any questions please contact Member Services toll-free at 1-888-901-4636, (TTY Relay: 711 or 1-800-833-6388). Or visit [kp.org/wa](http://kp.org/wa), click on "Member Services" and send an email.

Reimbursement requests will be processed within 60 days of receipt.

**Itemized receipts, invoices, and proof of payment** must be submitted, otherwise form may be sent back for lack of information.

Submit all documents to:

**Claims Processing  
Kaiser Permanente  
P.O. Box 30766  
Salt Lake City, UT 84130-0766**

**Member Reimbursement Form for Medical Claims**

Please complete all items on the claim form. If the information requested does not apply to the patient, indicate N/A (Not Applicable).

Special care should be taken when completing the following sections:

- 10. Practitioner Information** - Please fill out attending practitioner's name with the physician that was seen for services. Please fill referring practitioner's name with the physician that referred you if applicable.
- 11. Provider Information** - Please fill out provider name with the name of the facility that was visited. Please fill out Provider Tax ID with the facility's Tax ID (this number will need to be obtained from the provider). Please fill out provider billing address with the facility's address.
- 12. Condition was related to** - Please indicate if the injury or reason of visit was related to your employment (L&I), or an auto accident, and if yes to either of them please indicate the date of accident.
- 13. Itemization** - This information must be obtained from your provider, or must be included on your itemized statement from your provider. If this information is included on your itemized statement you can state please review attached itemized statement.
- 14. Foreign Claims** - Please complete this section if your services were completed outside of the country, otherwise indicate N/A.
- 15. Proof of payment** - Please indicate what type of proof of payment you have attached with this form.
- 16. Payment information** - Please answer each question by checking the box that applies to the payment(s) you made to the provider.
- 17. Other insurance** - Please indicate whether you have coverage from another insurance, if applicable the name of the subscriber for the other insurance and the name of the other insurance, and indicate by checking the box if they made a payment.
- 18. Signature** - This form must be signed and dated by either the subscriber or the patient.