Independence

Independence Administrators

SUBSCRIBER CLAIM FORM

This claim form must be completed using **Black** ink.

IDENTIFICATION NUMBER	GROUP NUMBER	COPY THE INFORMATION FROM YOUR Independence Administrators MEMBER ID CARD
	N/A	

SUBSCRIBER'S LAST NAME	SUBSCRIBER'S FIRST NAME	SUBSCRIBER'S BIRTHDATE MO / DAY / YR

PATIENT'S LAST NAME	PATIENT'S FIRST NAME	PATIENT'S BIRTHDATE MO / DAY / YR

PATIENT'S SEX	PATIENT'S RELATIONSHIP TO SUBSCRIBER	IS CONDITION JOB RELATED?
☐ MALE ☐ FEMALE	☐ SELF ☐ SPOUSE ☐ UNMARRIED DEPENDENT	☐ YES ☐ NO

SUBSCRIBER'S STREET ADDRESS	CITY	STATE	ZIP CODE	FOREIGN CLAIM?
				YES ☐ NO ☐

IS THIS SERVICE RELATED TO:	MO.	DAY	YR.	
☐ ILLNESS ☐ INJURY ☐ MATERNITY ☐ AUTO ACCIDENT				IF ILLNESS, DATE OF FIRST SYMPTOM IF INJURY or ACCIDENT, DATE OF INJURY or ACCIDENT IF MATERNITY, DATE OF LAST MENSTRUAL PERIOD

	ADMISSION DATE			DISCHARGE DATE			NAME OF ADMITTING PHYSICIAN	NAME OF HOSPITAL
IF HOSPITALIZED:	MO	DAY	YR.	MO.	DAY	YR.		

SYMPTOMS AND/OR DIAGNOSIS

NAME OF PROVIDER	PROVIDERS ADDRESS

OTHER COVERAGE INFORMATION

For claims related to an injury or auto accident, please provide the name and address of the other carrier, if applicable.

IDENTIFICATION NUMBER _____ GROUP NUMBER _____

NAME OF INSURANCE COMPANY _____

ADDRESS _____

YOU MUST INCLUDE A COPY OF YOUR EXPLANATION OF BENEFITS, if you have other health care insurance as primary coverage, have an auto or worked related injury, or have Medicare benefits

Does the patient have other insurance coverage? Yes ☐ No ☐

IDENTIFICATION NUMBER _____ GROUP NUMBER _____

NAME OF INSURANCE COMPANY _____

ADDRESS _____

Does the patient have Medicare Coverage: Yes ☐ No ☐

MEDICARE NUMBER _____

Is the patient eligible for Medicare Part A? Yes ☐ No ☐

Is the patient eligible for Medicare Part B? Yes ☐ No ☐

I hereby certify that the statements provided by me are correct and acknowledge that I will refund to Independence Administrators duplicate payments to myself from other sources because of coordination of benefits. I authorize the provider of services, named above, to release the information requested on this form to Independence Administrators. **A person who files a claim with the intent to defraud or helps commit a fraud against an insurer is guilty of a crime.**

Signature: _____ Date: _____

IMPORTANT, PLEASEREADTHEFOLLOWING: Claims must be submitted with the time frame specified by your contract.

HOWTOSUBMITYOURCLAIM:

1. Complete one Subscriber Claim Form for each patient and for each provider.
2. Answer all questions.
3. Attach a copy of the **itemized bill** and **proof of payment.** The bill should show:
    - The patient full name
    - The provider's name and address and Federal tax ID and National Provider Identifier (NPI)
    - The diagnosis or the symptoms of illness
    - The date of service, place of service and type of service
    - The charge for each service
    - The procedure and diagnosis code(s) and description(s)
    - Please be sure that a physician's medical certification accompanies bills for purchase or rentalof medical equipment
4. Attach a copy of your Explanation of Health Care Benefits, if you have other coverage as primary.
5. Sign and date the form (electronic signature is acceptable).
6. Scan the completed form and all attached documents and send via email to **memberclaims@ibxtpa.com** (Recommended/Preferred)
7. or you can mail this form to:

   Independence Administrators
   c/o Processing Center
   P.O. Box 21974 • Eagan, MN 55121

8. You do not need to submit a claim form for prescription drug purchases made at network pharmacies. The pharmacist will file the claim for you. If you purchase your prescription at a non-network pharmacy, you may still be entitled to reimbursement or a portion of your prescription drug expenses by completing Section 3 of this claim form. Be sure to include itemized receipts for each prescription. Remember to ask your pharmacist for the NDC number of the drug you purchased, and record that number in Section 3 on the front of this form.

The form will not be accepted or processed if any of the above information is incorrect or missing. Once all information is received and verified, the request may take up to 30 days to be finalized and paid.

NOTE: We cannot return the claim or documentation that you send. Please make copies for your personal files.

Nondiscrimination Notice and Notice of Availability of Auxiliary Aids and Services

Independence Administrators complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Independence Administrators does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Independence Administrators:

- Provides free aids and services to people with disabilities to communicate effectively with us and written information in other formats, such as large print
- Provides free language services to people whose primary language is not English and information written in other languages

If you need these services, contact our Civil Rights Coordinator.

If you believe that Independence Administrators has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our Civil Rights Coordinator.

There are four ways to file a grievance directly with Independence Administrators:

- by mail: Independence Administrators,
  ATTN: Civil Rights Coordinator, 1900 Market Street, Philadelphia, PA 19103;
- by phone: 888-356-7899 (TTY 711),
- by fax: 215-761-0920, or
- by email: **IACivilRightsCoordinator@ibxtpa.com**.

If you need help filing a grievance, our Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf** or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800- 537-7697 (TDD). Complaint forms are available at **http://www.hhs.gov/ocr/office/file/index.html**.

Language Access Services

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-844-864-4352 (TTY: 711).

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-844-864-4352 (TTY: 711).

注意：如果您使用简体中文，您可以免费获得语言协助服务。请致电1-844-864-4352。

LƯU Ý: Nếu quý vị nói tiếng Việt, có dịch vụ trợ giúp ngôn ngữ miễn phí dành cho quý vị. Xin gọi số 1-844-864-4352.

ВНИМАНИЕ: Если вы говорите по-русски, вам предлагаются бесплатные услуги переводчика. Позвоните по телефону 1-844-864-4352.

Wann du [Deitsch (Pennsylvania German / Dutch)] schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-844-864-4352.

알림: 한국어 통역서비스가 필요한 분은 1-844-864-4352 으로 전화하십시오. 통역서비스를 무료로 받으실 수 있습니다.

ATTENZIONE: se parla italiano, sono disponibili per lei servizi di assistenza linguistica gratuiti. Contatti il numero 1-844-864-4352.

انتباه: إذا كنت تتحدث العربية فإن خدمات المساعدة اللغوية متوفرة لك مجاناً. اتصل على الرقم: 1-844-864-4352.

ATTENTION: Si vous parlez français, des services d'assistance linguistique gratuits sont à votre disposition. Appelez le 1-844-864-4352.

HINWEIS: Wenn Sie Deutsch sprechen, steht Ihnen über Language Assistance Services ein Dolmetscher kostenlos zur Verfügung. Wählen Sie 1-844-864-4352.

[illegible] 1-844-864-4352 [illegible].

UWAGA: jeśli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-844-864-4352.

ATANSYON: Si ou pale kreyòl ayisyen, gen asistans ak lang disponib pou ou gratis. Rele 1-844-864-4352.

[illegible] 1-844-864-4352 ។

ATENÇÃO: se você fala português, serviços de assistência a idioma estão disponíveis gratuitamente para você. Ligue para 1-844-864-4352.

BAA ÁKONÍNÍZIN: Bilagáana bizaad bee yáníłti'go , saad bee áká anáʼálwoʼ, t'áá jíík'e bee ná ahóót'i'. Kojį' hólne' 1-844-864-4352

PAUNAWA: Kung nagsasalita ka ng Tagalog, makakakuha ka ng mga serbis yo ng tulong para sa wika nang walang bayad. Tumawag sa 1-844-864-4352.

注意：日本語をお話しになる場合は、言語支援サービスを無料でご利用いただけます。1-844-864-4352 にお電話ください。

توجه: اگر به زبان فارسی صحبت می کنید، خدمات کمک در زمینه زبان، به رایگان در اختیار شما می باشد. با شماره 1-844-864-4352 تماس بگیرید.