Member Submitted Claim Form

motivhealth®

P.O. Box 709718
Sandy, UT 84070-9718
(844) 234-4472

Thank you for choosing MotivHealth Insurance Company for your health care coverage. Please review the filing instructions located at the end of this form before you begin for helpful information regarding how to complete your claim so that it will process quickly and accurately. Contact customer service using the toll-free number on your MotivHealth Insurance Company member identification card if you have any questions. We are happy to serve you.

MEMBER INFORMATION

Patient's Name (Last, First, M.I.)	Patients Date of Birth (mm/dd/yyyy)	Patient's Sex ☐Male ☐Female
Policyholder's Name (Last, First, M.I.)	Patient's Relationship to Policyholder ☐Self ☐Spouse ☐Dependent	

Policyholder's Address	City	State	Zip	Telephone Number
Patient's ID Number	Employer Name			Group ID

Did you present your Insurance Card to the provider? ☐No. ☐Yes. Please advise your provider you do not want a claim submitted on your behalf.

Does the patient have primary coverage from any other health plan, including Medicare? Call 844-234-4472 if you have question about double coverage.

☐ No. Please skip to Claim Details.
☐ Yes. Please attach the Explanation of Benefits (EOB) statement from the primary plan with this claim, and complete the following information.

Name of Other Health Plan	ID/Policy Number of Other Health Plan	Telephone Number of Other Health Plan
Provider Tax ID	Diagnosis Codes - (not just description)	
Provider NPI	CPT/Procedure Codes	

Note—Breakdown of charges and proof of payment is required.

CLAIM DETAILS

Name of Provider	Address where services were rendered	Date of Service (mm/dd/yyyy)
Provider Tax ID	Provider NPI	Provider Phone Number

In what setting were these services performed?
☐Inpatient Hospital ☐Outpatient Hospital ☐Office/Clinic ☐Surgery Center
☐Skilled Nursing Facility ☐Home ☐Other

Date of Service (mm/dd/yyyy)	Diagnosis Code(s) - not just description	CPT/Procedure Codes

If additional lines are needed, please detail the dates of service and Diagnosis/CPT codes on an additional page.

Total charges must be paid in full prior to claim submission. Please attach proof of payment in full with your itemized bill.	Total Charges

If applicable, list the contact information of the physician that prescribed/ordered these services:

Name	Address	Telephone Number

INTERNATIONAL SERVICES

Is this claim for expenses incurred outside the U.S.A.?

☐ **No. Please skip to Accident/Injury. ☐ Yes. Please supply an itemized bill and any available medical records when you submit the claim.**

Name of Provider	Country of Service	City of Service	Date of Service (mm/dd/yyyy)

Diagnosis (describe illness and symptoms requiring treatment):	Total Charges	Currency Used

Briefly describe the services(s) you received:

ACCIDENT/INJURY

Is this claim due to an accidental injury? ☐No. Please skip to Signature. ☐Yes. Please complete this section.	Date of Service (mm/dd/yyyy)	Where did the accident occur? ☐Home ☐Work ☐School ☐Auto ☐Other

How did the accident happen?

Description of Injury:

Please Note: If there is another party that may be responsible to pay for these services, such as homeowner's or auto insurance, please include a completed accident form when submitting your claim. Contact an agent in our Other Party Liability department at 844-234-4472 for assistance in completing this form.

SIGNATURE

To be accepted, this form must be fully completed (as appropriate to the claim being submitted) signed, and have an itemized bill attached.

Patient's Signature (or legal guardian if patient cannot legally consent to services)	Relationship to Patient ☐Self ☐Other	Date (mm/dd/yyyy)

Please Note: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefit.

I certify that the above statements are correct and hereby authorize any physician, hospital, employer, union, insurance company, or prepayment organization to supply MotivHealth and its agents any information required in connection with this claim. A photocopy of this authorization shall be as valid as the original.

Signature (Subscriber or Patient) **Date**

Thank you for choosing MotivHealth Insurance Company as your health plan administrator. We recommend that you make copies of everything that is submitted for your personal records.

Mail this claim to:
MotivHealth Insurance Company
P.O. Box 709718
Sandy, UT 84070-9718
(844) 234-4472

Or submit via email to:
pha@motivhealth.com

INSTRUCTIONS FOR FILING A CLAIM

IMPORTANT:

- You only need to fill out this form if your health care professional isn't filing the claim for you. Your health care professional can still file the claim for you if they are out-of-network with your policy, however, they are not required to do so.

- If services are a result of an accident or injury, complete the Accident/Injury section of the claim form and include a completed accident form with your claim. You can locate our accident form at **motivhealth.com/forms-documents**. If you need assistance completing this form, you can contact an agent in our Other Party Liability department at **844-234-4472**.

- If you have Medicare or other insurance coverage that is not already on file with MotivHealth Insurance Company, or if it has changed or terminated, please call us at 844-234-4472 to update your account to ensure your claim processes correctly and timely.

FILING INSTRUCTIONS:

- Complete a separate claim form for each covered family member.
- Enclose itemized receipts and make copies for your records. It is helpful for receipts to include:

  Patient's Name
  Date of Service (mm/dd/yyyy)
  Procedure Code(s)
  Diagnosis Code(s) – ICD Format (if available)
  Health care professional's Full Name, Credentials, Address, Phone Number and Tax ID Number and National Provider Identifier (NPI), Total charge for each service rendered

- If the patient has Medicare or other health insurance coverage, and that other insurance coverage is primary and MotivHealth is secondary, we need an Explanation of Benefits (EOB) for this service from the other insurance company when you send the completed form and itemized bill.

One claim form may be submitted for multiple dates of service provided they are for the same member and same provider.

Member-submitted claim forms need to be submitted within 365 days of the date services were rendered. We may request additional information for the procedure to be reviewed if the services and/or procedures require Prior Authorization.

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