Welcome!

Terms and Conditions of Use:

1. This site provides an electronic version of your Claim Form. It is provided as a convenience to employers and employees.

2. We strive to ensure that the contents of this site are correct and complete, but to verify your benefits, please call HealthPartners Member Services.

3. This information is not an offer of coverage or guarantee of coverage. All products are subject to applicable laws and regulations. Your coverage is contingent on all the applicable terms, conditions, limitations and exclusions of your plan documents.

4. Any alteration of this PDF file is unauthorized.

5. By accessing and using this site, I agree to these terms and conditions.

HealthPartners names and logos and all related products and service names, design marks and slogans are the trademarks of HealthPartners or its related companies.
IMPORTANT: Please be sure to include all information requested. Missing information will delay the processing of your claims.

This claim form is to be used by enrolled employees and their dependents when requesting payment for medical services, including prescription drugs.

Please:
1. Complete the form. Refer to your member card for the member number.
2. If you have questions related to the claim or completion of the form, please call (952) 883-7755.
3. Attach itemized medical bills.
4. Send the completed form **within 15 days** to:

   HealthPartners
   P.O. Box 1289
   Minneapolis, MN 55440-1289

Patient Name: _____________________________ Relationship to Policyholder_____________________________

Member Number:_____________________________

INSURANCE INFORMATION UPDATE

HealthPartners Policyholder name__________________________________________________________
Name of Spouse of Policyholder_____________________________ Spouse Date of Birth ______________

Is Policyholder’s spouse employed? □ YES □ NO
If YES, Name of Employer ____________________________________________________________

Is Policyholder’s spouse covered under his/her employer’s health plan □ YES □ NO
If YES, complete the following:
   Name of other insurance company _______________________________ Phone Number ______________
   Address ____________________________________________________________________________
   Policy/Group # __________________________________________ Effective Date __________________
   □ Single coverage □ Family coverage

1. Was this care a result of an Accident/Injury? □ YES □ NO
2. Was the illness related to your work, motor vehicle, or any other third party? □ YES □ NO
3. Is patient covered by another medical policy not listed above? □ YES □ NO
4. Is the Policyholder or Spouse of Policyholder covered by any other medical policy not listed above? □ YES □ NO
5. Is the Policyholder or Spouse of Policyholder divorced and/or remarried with dependents? □ YES □ NO

If you answered YES to either questions number 1 or 2, please complete **Section A** on reverse side.
If you answered YES to either questions number 3, 4, or 5, please complete **Section B** on reverse side.
If you answered NO to all of the above questions, please sign, date and return.

I HEREBY DECLARE THE ABOVE INFORMATION TO BE TRUE AND ACCURATE.

HealthPartners Policyholder signature ______________________________ Date _______________
**ACCIDENT OR ILLNESS INFORMATION UPDATE**

**Date of original illness or injury resulting in this claim (if unknown, date first seen by a doctor)**

_____________________________

**If illness, please describe**

_______________________________________________________________________

_______________________________________________________________________________________

**If injury, give details of how injury occurred**

____________________________________________________________

_______________________________________________________________________________________

**Where did injury occur?**

________________________________________________________________________

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**OTHER PARTY INSURANCE COVERAGE**

Type of coverage related to the injury:

- [ ] Automobile
- [ ] Personal Injury
- [ ] Work Related
- [ ] Homeowners Liability
- [ ] Other (please describe)

If you checked any of the above, please provide the following:

Person or establishment with possible financial responsibility for the injuries

<table>
<thead>
<tr>
<th>Name</th>
<th>Address</th>
<th>Phone number</th>
</tr>
</thead>
</table>

Responsible insurance carrier, if known

<table>
<thead>
<tr>
<th>Name</th>
<th>Address</th>
<th>Phone number</th>
</tr>
</thead>
</table>

Attorney, if one is retained

<table>
<thead>
<tr>
<th>Name</th>
<th>Phone number</th>
</tr>
</thead>
</table>

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**Section B**

If Policyholder, Spouse, or Dependent(s) are covered by another medical policy, please complete the following:

<table>
<thead>
<tr>
<th>Name of person covered</th>
<th>Health plan name, address and phone number</th>
<th>Policyholder name and policy number</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
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<tr>
<td>2.</td>
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<tr>
<td>3.</td>
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</tr>
</tbody>
</table>

If you are divorced and/or remarried with dependents, please complete the following:

<table>
<thead>
<tr>
<th>Child’s complete name</th>
<th>Name of person(s) with legal custody</th>
<th>Name and date of birth of person(s) responsible for dependent health care expenses per divorce decree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
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<tr>
<td>2.</td>
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<tr>
<td>3.</td>
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<td></td>
</tr>
</tbody>
</table>

Are any of the children listed above also covered under another health insurance plan?  

- [ ] YES  
- [ ] NO  

If YES, please complete the following:

<table>
<thead>
<tr>
<th>Name of person covered</th>
<th>Health plan name, address and phone number</th>
<th>Policyholder name and policy number</th>
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</table>

If additional space is needed for any section, please provide on a separate page.

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**COORDINATION OF BENEFITS AND UTILIZATION /CLAIMS REPORTING AUTHORIZATION**

I authorize HealthPartners to release general medical information regarding my family's treatment to the administrators of any other health plan providing coverage to me or my dependents. I authorize the administrators of any other health plan providing coverage to me or my dependents to release information to HealthPartners regarding health care benefits to which we may be entitled. I understand that the purpose of the release of information is to assure proper coordination of benefits of all plans. I understand that HealthPartners may release information regarding services provided under my health benefits contract when requested by the employer/organization sponsoring my health benefits plan. This information will be reported without identification of individuals to maintain patient confidentiality. This authorization shall remain valid for the duration of the coverage of the plan for which a claim is submitted. I understand a photocopy of this authorization shall be as valid as the original.

**I UNDERSTAND THAT A PERSON WHO FILES A CLAIM WITH INTENT TO DEFRAUD OR HELPS COMMIT A FRAUD AGAINST AN INSURER IS GUILTY OF A CRIME. I HEREBY DECLARE THE ABOVE INFORMATION TO BE TRUE AND ACCURATE.**

HealthPartners Policyholder signature ___________________________ Date ____________________

Thank you for your cooperation. We will hold your claim open for fifteen days to allow you time to submit the necessary information. If you have any questions related to the claim or completion of this form, please call (952) 883-7755.