Medical and/or Dental Need Reimbursement Form

Name:	M.I.:	Last Name:
Mailing Address:		City:
State:	Zip:	Phone Number:

Patient Gender:	Patient Date of Birth:
Member ID #:	Payor #: Group #:
Patient's Relationship to Primary Member: **Self** / **Spouse** / **Dependent**	
Member's Effective Date:	Program Name:

If a member receives services from an In-Network Provider, reimbursements will be processed based on the lesser of the In-Network Re-Priced Amount or the Self-Pay discount provided. Any over payments will be due from the provider to the member.

Provider Full Name:	Provider Tax Id #:
NPI Number (10 digit #):	Group/Facility Name:
Address:	City:
State: Zip:	Phone Number:

Select one of the following Types of Service below:

Injury: Date of Service ____ / ____ / 20____	**Dental:** Visit Date ____ / ____ / 20____
Pregnancy: Date of Service ____ / ____ / 20____	**Wellness:** Date of Service ____ / ____ / 20____
Office Visit: Visit Date ____ / ____ / 20____	**Other Type:** Date of Visit ____ / ____ / 20____

Please provided a brief overview for the reason of the visit for you or your family member.

Please provide one of the following forms:
UB04 or HCFA1500 or "Superbill"-provides Procedure Codes (CPT), Diagnosis Codes (ICD-10), Modifiers, additional pieces of data to avoid need denial. We will need the Date of Service, Procedure Codes & Description (CPT), Diagnosis Codes / Description (ICD-10 or ICD-9) Modifiers (if applicable), Units or Minutes to indicate count / number of units for given code, Fees Charged, and Receipts.

Signature:
By signing below, I am stating all information herein is correct. I realize any person who knowingly sumbits a medical and/or dental need reimbursement containing any misrepresentation or any false, incomplete, or misleading information may have their JHS Community membership cancelled.

Member's Signature: X _____ Date: _____ / _____ / _____

Only eligible medical and/or dental needs that have a proof of payment will be shared directly to the member. Otherwise, eligible needs will be shared directly to the billing provider. Please SUBMIT using ONE of the below options:

Email to: providerservices@jhscommunity.org

Fax to: 866-443-7563