



SUBSCRIBER MEDICAL CLAIM FORM

A. PATIEN	IT INFORI	MATIC	N										
1. NAME (LAST NA	7. PATIENT'S SUBSCRIBER ID (CONTRACT) NUMBER (INCLUDE ALPHA PREFIX) ZU												
2. ADDRESS LINE	8. PATIENT SOCIAL SECURITY NUMBER				9. PRIMARY TELEPHONE NUMBER								
3. ADDRESS LINE 2						10. FAX NUMBER			11. ALTERNATE TELEPHONE NUMBER				
4. CITY				5. STATE	6, ZIP CODE	12. GROUP NUMBER (See ID Card)			13. GROUP NAME				
B. OTHER	INSURAN	ICE IN	FORMA	ATION (CO	ORDINATION OF	BENEFITS)				<u> </u>			
14. DOES PATIEN	T HAVE OTHER	HEALTH	INSURANCE	E PLAN?		15. IS PATIENT ME	DICARE E	LIGIBLE?					
	□ NO □ YES												
If yes, complete info	If yes, include Medicare plan type and HICN (Claim Number) below: 17. MEDICARE CLAIM NUMBER (HICN)												
10. NAME OF OTT	ILIV II VOOI VAINOL	_ OOWII AI	VI OIXI LAI	•		17. MEDIOARE GEA	AIW NOWD	LIC (IIIOI4)				Part A Part B	
18.POLICY/ CONTRACT NUMBER 19. GROUP NUMBER					ΞR	When submitting charges for covered services or supplies that have been					nat have been		
20. OTHER INSURANCE TELEPHONE NUMBER 21. OTHER				1. OTHER INSURA	ANCE FAX NUMBER	partially paid or declined by other group health insurance, attach a copy of the Notice of Payment or Explanation of Benefits from the other insurance carrier along with the itemized bills. For Medicare charges, include the Medicare Explanation of Benefits (MEOB).							
22. OTHER INSURANCE ADDRESS						23. FOR TRIPLE- S SALUD USE ONLY							
			NFORM	ATION (Co	mplete only if the cla	im was due to a	an accid	lental in	jury)				
24. PATIENT CON ACCIDENT			O ACCIDE	емт Потн	ER ACCIDENT, describe:								
25. DATE OF ACC		L AUI		OF ACCIDENT	27. DID ANOTHER PERSO	N CAUSE THIS	28. CAN	THE OTHE	R PERS	ON BE CONSI	DERED LEGAL	LY RESPONSIBLE	
(MONTH/DAY/YEAR)			AM / PM ACCIDENT?		NO YES FOR THIS ACCIDENT?				□ NO □ YES				
D. PATIEN	IT AUTHO	RIZA	TION										
any hospital, phy	sician, or othe	er health o other info	care institu ormation re	tions or provider quested for the	ect and complete, and that is who participated in the coupurpose of evaluating and with the coupurpose of evaluating and with the coupur and with the coupur and the coupur	care treatment of the processing of this	ne patient benefit c	to release					
E. INFORM	MATION C				OR SUPPLIES	VIATIVE GIGIVAT	JIKE			DATE			
						IER ID (National Provider Identifier -NPI)							
33. PROVIDER/SUPPLIER ADDRESS					34. PROVIDER SPECIALTY	34. PROVIDER SPECIALTY 35. PATIENT ACCOUNT OR RECO						RECORD NUMBER	
						SERVICES RENDERED IN: Puerto Rico U.S. Outside of P.R. or U.S.						NUMBER	
38 DIAGNOSIS ICD					Puerto Rico	utside of	P.R. or U	.S.	39 PLAN PRI	PLAN PREVIOUS AUTHORIZATION NUMBER			
					Indicate where:								
40 DATE OF	SERVICE	TYPE	PLACE OF	OFF	//OF DECODIDATION	PROCEDURE	MOD	DAYS /	TRIPL	.E-S SALUD	TOTAL	TRIPLE-S SALUD	
FROM MM/DD/YYYY	TO MM/DD/YYYY	TTPE	SERVICE	SERV	/ICE DESCRIPTION	CODE	MOD	UNITS	US	E ONLY	PAID	USE ONLY	
1													
2													
3													
4													
5													
6													
SIGNATURE OF P DEGREES OR CR		UPPLIER	INCLUDING	PRC	IVIDER OR SUPPLIER STAM	P			TRIF	PLE-S SALUI	OUSE ONLY	,	
SIGNED)	D	ATE				1						

PLEASE READ THIS IMPORTANT INFORMATION

FOR THE PATIENT / SUBSCRIBER SUBMITTING THE CLAIM

- 1. Use this form for all your covered medical, surgical, hospital services, procedures, supplies claims and prescription drugs.
- 2. Complete all applicable fields, date and sign the form.
- 3. If you are submitting expenses for more than one family member, please use a separate claim form for each person.
- Use a separate claim form for services rendered or items supplied in different plan years.
- 5. Please include and attach original itemized bills and Explanation of Benefits for all claimed services or supplies.
- 6. Each itemized bill must be legible and MUST include the following information:
 - o Name and address (in letterhead) of provider or institution rendering service or supplying the item;
 - Provider's Name, Address;
 - o National Provider Identifier (NPI) and one of the following numbers: Tax Id or State License.
 - Patient's Full Name
 - o Type of service rendered or item supplied (office visit, chest x-ray, etc.)
 - o Date of each service rendered or item supplied
 - o Amount charged for each service rendered or item supplied
 - o Diagnosis of ailment (the medical condition for which the patient was treated).
 - All drugs prescription forms should include the following: payment receipt with prescription number, prescription name, NDC, amount dispensed and amount paid for each prescription.
 - o Include your TRIPLE-S SALUD subscriber identification (contract) number clearly on each bill or document.

NOTE: Stand alone cash register receipts, cancelled checks, money order receipts, personal itemizations, and bills only noting "Balance Due" are NOT acceptable.

ADDITIONAL INFORMATION REQUIRED FOR CERTAIN CLAIMS

Bills for the following covered services must also include:

- Ambulance Service: A statement of medical necessity from the attending doctor which indicates why ambulance transport was required and an itemized bill from the ambulance provider showing the amount paid for transport, date and miles traveled.
- 2. **Private Duty Nurse**: Copy of the plan's previous approval (pre-authorization), the type of nurse (RN or LPN), license number, the shift and hours worked and a statement of medical necessity for the prescribing doctor.
- 3. **Durable Medical Equipment** (wheelchair, oxygen tank, etc.): Copy of the plan's previous approval (pre-authorization), a statement of medical necessity from the prescribing doctor which indicates how long the equipment will be used and a statement from the equipment supplier showing both the rental and purchase price.
- 4. Surgical Assistance (when surgical procedure required assistance of another surgeon): Copy of the Surgical Report and include full name of surgical assistant.
- 5. Anesthesia: Anesthesiologists invoice or payment receipt must include service minutes or units.

BILLS MISSING ANY OF THIS INFORMATION WILL DELAY PROCESSING AND MAY BE RETURNED TO YOU.

COORDINATION OF BENEFITS INFORMATION

If you or any of your dependents is covered by another health insurance program, please provide the information requested in section 3 OTHER INSURANCE INFORMATION.

When submitting charges for covered services or supplies that have been partially paid or declined by other group health insurance, attach a copy of the Notice of Payment or Explanation of Benefits from the other insurance carrier along with the itemized bills.

MEDICARE

If PATIENT is eligible for Medicare benefits, make sure to include the Explanation of Medicare Benefits (EOMB) that was sent to the patient explaining the charges paid or not paid by Medicare. If your EOMB has multiple pages, send us copies of all pages.

INSURANCE FRAUD WARNING

Any person who, knowingly and with the intent to commit fraud, provides false information in an insurance application, or provides, helps in providing or assists in the transmittal of a fraudulent claim for payment of loss, or any related benefit, or files multiple claims for the same loss or benefit, will incur in a felony, whereupon, if convicted, will be sanctioned with a economic fine of no less than five thousand (\$5,000) but no more than ten thousand (\$10,000) per violation, or incarceration for a mandatory term of three (3) years, or both. In case of aggravating circumstances, this term could be extended to a maximum of five (5) years; and in case of mitigating circumstances, it could be reduced to two (2) years.

Mail your completed claim form and documents to:

TRIPLE-S SALUD
Reimbursements Department
PO BOX 363628
San Juan, PR 00936-3628

