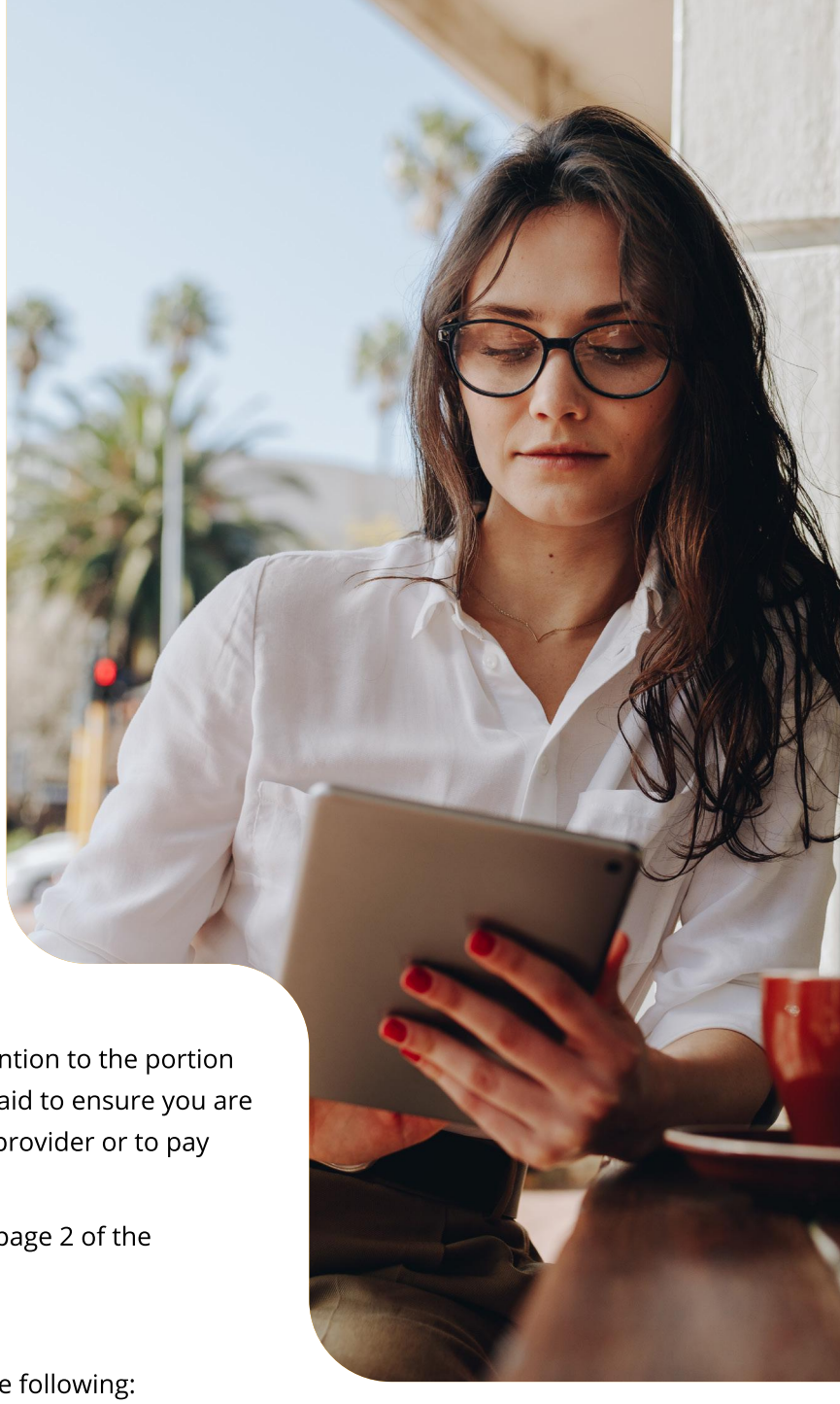
luminare health

Quick Guide: How to Submit Out of Network Claims



Your plan allows you to use out of network providers. To submit claims for reimbursement, you must fill out the Health Claim From and return it along with an itemized statement and proof of payment. For full instructions and additional information, please see the full instructions on the pages below.

Please note that the form must be completed in full and submitted with the necessary attachments to avoid delays in processing a reimbursement.

1. Fill out the claim form completely. Pay special attention to the portion pertaining to theauthorization of who should be paid to ensure you are only signing one of the options –either to pay the provider or to pay the member.
2. Either attach the itemized statement or complete page 2 of the claim form.
3. Attach proof of payment.
4. Submit your claim for reimbursement to one of the following:

A. Email:

HBEVclaimsubmission@luminarehealth.com and in the subject line write "FAES OON Claim Submission"

B. Portal:

a. Sign into your myluminarehealth.com account

b. From the **My Expenses** tab, select **Claim Submissions**

c. Click the "**Submit a Claim**" button

d. Mandatory fields are identified with a star – complete all mandatory fields

e. If you answer "Yes" to Accident Details and/or Other Coverage Information, additional mandatory fields will display

f. Click the "Save" button to save your changes

C. Mail To:

Luminare Health
PO Box 2920
Clinton, IA 52733-2920

Out-of-Network Claim Form Instructions

Your plan allows you to use out of network providers. To submit claims for reimbursement, you must fill out the enclosed Health Claim Form and return it along with an itemized statement and proof of payment. The instructions below will explain what needs to be done in each section before you can submit your claim for reimbursement. See "Additional Details" below for more information and suggestions to make submitting your out of network claim as quick and easy as possible.

At any time, if you should have any questions, please contact the **customer service number** on your identification card for assistance.

The following portions of the form MUST BE COMPLETED IN FULL TO AVOID DELAYS IN PROCESSING. If incomplete, the form may be returned to you.

1 **Employee Information:** This section pertains to the employee's information. Please fill in the blanks and select the appropriate check boxes.

EMPLOYEE INFORMATION:		Employment Status ☐ Active ☐ Retired ☐ Laid Off ☐ Disability Leave ☐ Other
Employee Name (Please print first name, middle initial, last name)	I.D. Number:	Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Legally Separated
Street Address: (street, city, state, zip code)		Date of Birth: Month/Day/Year
Employer's Name:		Group Number:

2 **Dependent's Information:** This section only needs filled out if the patient was a dependent (significant other or child) – otherwise, leave it blank. Be sure to fill in all blanks and select the appropriate check boxes.

DEPENDENT'S INFORMATION: (complete only if patient is a dependent)

Name of Dependent:	Relationship: ☐ Other (Explain) ☐ Spouse ☐ Child _____
Marital Status (other than spouse):	Date of Birth: Month/Day/Year
AT TIME CHARGES WERE INCURRED: (If answer to either is yes, give employer's name and address) Was spouse employed? ☐ Yes ☐ No	If claim was for child, was child employed? ☐ Yes ☐ No

3 **Complete for all Patients:** This section must be filled out completely for each patient; if there are multiple patients, please use separate forms. Please fill in the blanks and select the appropriate check boxes.

COMPLETE FOR ALL PATIENTS:

Diagnosis or nature of injury:	
When were you first treated for this condition? (month/day/year)	Name and address of physician who first treated you:
Is patient also covered for benefits by: a. Other Group Health insurance of any kind including Blue Cross and Blue Shield? ☐ Yes ☐ No b Group prepayment arrangement providing for medical care and treatment? ☐ Yes ☐ No c. Coverage of medical care expenses provided by a school, or by Medicare or other federal, state, provincial or government agency? ☐ Yes ☐ No d. No fault automobile insurance as a result of injuries sustained in an automobile accident? ☐ Yes ☐ No **If any of the above are answered YES please indicate in "Remarks" the policy number, insurance company and the name and address of the school, employer, union or government agency.**	**Was illness or injury due in any way:** a. To the patient's occupation? ☐ Yes ☐ No b. To an automobile accident? ☐ Yes ☐ No c. To any other type of accident? ☐ Yes ☐ No **If any of above are answered "Yes" give details under "Accident."**
Remarks:	
Accident:	
Date: (Time: ☐A.M. ☐P.M.)	(Place of accident: ☐Work ☐Other)
How did accident happen?	Name and address where accident occurred:

4 **Authorization to Pay Benefits to Physician:** This portion directs Luminare Health on who to pay for services. If this section is signed, we are required to pay the provider on your behalf. **If you have already paid the provider, DO NOT SIGN THIS LINE – leave it blank.** See #5 and Additional Details section for more on member reimbursement.

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I hereby authorize payment of Medical Benefits to Physician or supplier for services described within.

SIGNED (PATIENT, OR PARENT IF MINOR)

▶ _____ Date_____

5 **Authorization to Pay Benefits to Member:** This portion directs Luminare Health to reimburse a member when the member pays a provider directly for services rendered. For a member to receive reimbursement, this line must be signed and the "Authorization to Pay Benefits to Physician" line must be left blank. If this line is signed along with the line for "Authorization to Pay Benefits to Physician", then Luminare Health will be required to pay the provider directly.

AUTHORIZATION TO PAY BENEFITS TO MEMBER: I hereby authorize payment of Medical Benefits to Member for reimbursement of expenses paid out of pocket for the services described within.

SIGNED (PATIENT, OR PARENT IF MINOR)

▶ _____ Date_____

6 **Authorization to Release Information:** Your signature allows us to request any necessary medical information from your provider that may be needed to finish processing your claim(s); if you do not sign this, you will be responsible for supplying Luminare Health with any required documents (such as medical records or treatment plans) that you must obtain from your provider which can cause a delay in the processing of your claim. While you are not required to do so, we strongly suggest you sign this line.

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the release of any medical information necessary to process this claim.

SIGNED (PATIENT, OR PARENT IF MINOR)

▶ _____ Date_____

If you are attaching an Itemized Statement, you can disregard Page 2. See "Additional Details" for the information required to process claims to ensure your itemized statement contains the required information.

If you are attaching an Itemized Statement, you can disregard page 2 of the Claim Form.

1 **Patient Information:** Please note the Employee's ID number can be found on the ID card.

Patient's Name (First/MI/Last)	Patient's Birth Date (Mo/Day/Yr)	I.D. Number:

2 **Patient or Supplier Information:** Be sure to fill this portion out completely as this is the information that is pertinent to processing a claim. Please note that you can always ask your provider to fill this out on your behalf.

PHYSICIAN OR SUPPLIER INFORMATION			
Date of:	ILLNESS (first symptoms), or INJURY (Accident), or PREGNANCY (LMP)	Date patient first consulted you for this condition?	Has patient ever had same or similar symptoms? ☐ Yes ☐ No
Provider of care: (Please check) ☐ Attending ☐ Surgeon ☐ Consulting		If other than attending, give name of referring physician	
Name & address of facility where services rendered (if other than home or office)		For services related to hospitalization, give hospitalization dates. ADMITTED DISCHARGED	
DIAGNOSIS Please indicate ICD9-CM or DSM III codes. **PRIMARY** **SECONDARY**			

Date of Service	Place of Service*	CPT Procedure (identify)	Fully describe procedures, types of therapy, or services furnished for each date given, indicate whether primary or secondary (if mental therapy indicate length of session)	Charges	Amount Paid	**Balance Due**

Signature of Provider Date Signed Degree	Total Charge	Amount Paid	**Balance Due**

Your patient's account number	Provider I.D. number	Provider's name, address, zip code, and telephone number

Additional Details:

1 **Member Reimbursement –** To pay a member, all of the items outlined above must be included in the submission along with signing the "Authorization to Pay Benefits to Member" line.

PLEASE LEAVE THE "AUTHORIZATION TO PAY BENEFITS TO PROVIDER" LINE BLANK. If you sign this line, Luminare Health will be required to send the payment to the provider."

2 **Deadline for Submission:** Members have one (1) year from the date of service to submit claims for processing. If we do not receive the claim with 365 days from the date of service, the claim will be denied as it will be considered outside of the claims filing deadline.

3 **Place of Service:** This is where the services were rendered. The following list is at the end of Page 2 for your convenience.

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the release of any medical information necessary to process this claim.

SIGNED (PATIENT, OR PARENT IF MINOR)

_____ Date_____

4 **Itemized Statement –** Be sure to request this from your providers at the end of each visit as it contains all necessary information to process a claim. Please note that an itemized statements must contain the following to be used in place of filling out Page 2 of the Out-of-Network Claim Form:

- **a.** Physician's Name
- **b.** Physician's Address
- **c.** Dates of service
- **d.** Service Codes
- **e.** Diagnosis Codes
- **f.** Charges
- **g.** Patient's Name

5 **Requirements for Claim Processing:** The following information is required for a claim to be processed. While this information should be listed on the Itemized Statement, the provider can give you any of the missing information:

a. Patient Details:

i. Name

ii. Date of Birth

iii. Member ID: this is on your ID card

iv. Employer Group Number: this is on your ID card

b. Provider Details:

i. Name - both physician and office if they are not the same.

ii. Address

iii. Phone Number

iv. Tax ID number

v. NPI

vi. License Number (if applicable)

c. Visit Details:

i. Date of service

ii. Billed amount

iii. Place of Service – See "Additional Details"

iv. Length of session

v. Diagnosis Code

vi. Procedure/Service Code

d. Proof of Payment – the claim form MUST be accompanied by proof of payment. Acceptable proof of payment are as follows:

i. Paid credit card receipts

ii. Copy of front and back of cleared checks

iii. Invoice from the provider that indicates the amount paid

- Handwritten receipts must be on provider letterhead

Please see the page below to fill out the Out-of-Network claim form.

If you should have any questions, please contact the customer service number on your identification card for assistance.

If you have any questions or need assistance, please contact Customer Service at 1-888-270-2044.

luminare health®

Experience. Solutions. Results.

To Submit Claim Form:

EMAIL: HBEVClaimsubmission@luminarehealth.com

PORTAL: You can submit your claim through the messaging center of the portal by logging into www.myluminarehealth.com

MAIL TO: Address indicated on your identification card

HEALTH CLAIM FORM

INSTRUCTIONS: For details on filling out the form, please see the enclosed instructions. REMEMBER TO FILL OUT THE FORM COMPLETELY TO AVOID DELAYS.

EMPLOYEE INFORMATION:

Employment Status
☐ Active ☐ Retired ☐ Laid Off ☐ Disability Leave ☐ Other

Employee Name (Please print first name, middle initial, last name)	I.D. Number:	Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Legally Separated
Street Address: (street, city, state, zip code)		Date of Birth: Month/Day/Year
Employer's Name: **FAES**		Group Number: **FA**

DEPENDENT'S INFORMATION: (complete only if patient is a dependent)

Name of Dependent:	Relationship: ☐ Other (Explain) ☐ Spouse ☐ Child _____
Marital Status (other than spouse):	Date of Birth: Month/Day/Year

AT TIME CHARGES WERE INCURRED: (If answer to either is yes, give employer's name and address)
Was spouse employed? ☐ Yes ☐ No If claim was for child, was child employed? ☐ Yes ☐ No

COMPLETE FOR ALL PATIENTS:

Diagnosis or nature of injury:

When were you first treated for this condition? (month/day/year)	Name and address of physician who first treated you:

Is patient also covered for benefits by:
a. Other Group Health insurance of any kind including Blue Cross and Blue Shield? ☐ Yes ☐ No
b Group prepayment arrangement providing for medical care and treatment? ☐ Yes ☐ No
c. Coverage of medical care expenses provided by a school, or by Medicare or other federal, state, provincial or government agency? ☐ Yes ☐ No
d. No fault automobile insurance as a result of injuries sustained in an automobile accident? ☐ Yes ☐ No

If any of the above are answered YES please indicate in "Remarks" the policy number, insurance company and the name and address of the school, employer, union or government agency.

Was illness or injury due in any way:
a. To the patient's occupation? ☐ Yes ☐ No
b. To an automobile accident? ☐ Yes ☐ No
c. To any other type of accident? ☐ Yes ☐ No

If any of above are answered "Yes" give details under "Accident."

Remarks:

Accident:

Date: (Time: ☐ A.M. ☐ P.M.) (Place of accident: ☐ Work ☐ Other)

How did accident happen?	Name and address where accident occurred:

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I hereby authorize payment of Medical Benefits to Physician or supplier for services described within.

SIGNED (PATIENT, OR PARENT IF MINOR)

▶ _____ Date_____

AUTHORIZATION TO PAY BENEFITS TO MEMBER: I hereby authorize payment of Medical Benefits to Member for reimbursement of expenses paid out of pocket for the services described within.

SIGNED (PATIENT, OR PARENT IF MINOR)

▶ _____ Date_____

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the release of any medical information necessary to process this claim.

SIGNED (PATIENT, OR PARENT IF MINOR)

▶ _____ Date_____

STOP — If attaching an itemized statement, do not complete this side.

Itemized statements must show Physician's name and address, dates and types of services, charges, patient's name and diagnosis.

Patient's Name (First/MI/Last)	Patient's Birth Date (Mo/Day/Yr)	I.D. Number:

VERIFICATION OF SERVICES

In order to process your bill for services as part of your patient's claim for healthcare expense reimbursement, we require the following data. **Your cooperation is appreciated.**

PHYSICIAN OR SUPPLIER INFORMATION

Date of:	ILLNESS (first symptoms), or INJURY (Accident), or PREGNANCY (LMP)	Date patient first consulted you for this condition?	Has patient ever had same or similar symptoms? ☐ Yes ☐ No

Provider of care: (Please check) ☐ Attending ☐ Surgeon ☐ Consulting	If other than attending, give name of referring physician

Name & address of facility where services rendered (if other than home or office)	For services related to hospitalization, give hospitalization dates. ADMITTED DISCHARGED

DIAGNOSIS Please indicate ICD9-CM or DSM III codes.
PRIMARY **SECONDARY**

Date of Service	Place of Service*	CPT Procedure (identify)	Fully describe procedures, types of therapy, or services furnished for each date given, indicate whether primary or secondary (if mental therapy indicate length of session)	Charges	Amount Paid	**Balance Due**
Signature of Provider Date Signed Degree				Total Charge	Amount Paid	**Balance Due**

Your patient's account number	Provider I.D. number	Provider's name, address, zip code, and telephone number

If the services were rendered by a psychiatric worker, the following certification must be completed by the attending physician.

Therapy performed by _____
was conducted at my direction and under my supervision and I have consulted with the Therapist regarding the patient within the last 90 days. Further, I have reviewed and approved the Plan of Treatment and have examined the patient on the date indicated below.

_____ Name of Attending Physician

_____ Address of Attending Physician

_____ Date of Examination

_____ Attending Physician's Signature

_____ Professional Status

***Place of service codes**

1 - (IH)	Inpatient Hospital	4 - (H)	Patient's Home	7 - (NH)	Nursing Home	O - (OL)	Other Location
2 - (OH)	Outpatient Hospital	5 -	Day Care Facility (Psy)	8 - (SNF)	Skilled Nursing Facility	A - (IL)	Independent Laboratory
3 - (O)	Doctor's Office	6 -	Night Care Facility (PSY)	9 -	Ambulance	B -	Other Medical Surgical Facility