

# Request for Payment of Medical Services

**Request for payment to:**

- Doctor or provider  
 Subscriber    Member (Proof of payment must be included for subscriber or member; see reverse.)

MEMBER INFORMATION			
First name	Middle initial	Last name	Date of birth MM/DD/YYYY
Street			
City		State	ZIP
Member ID number	Home telephone (     )	Work telephone (     )	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
PHYSICIAN OR PROVIDER OF SERVICE INFORMATION			
Provider or facility where services received		NPI or tax ID number of provider of service	
Address of provider or facility where services received			
Name of referring physician (if applicable)			
DIAGNOSIS			
Date of service MM/DD/YYYY	Provider of service	Charge	Amt. paid
Description of service			
INTERNATIONAL SERVICE INFORMATION (Complete if service was outside the U.S.)			
Country where services were rendered		Language of documentation	
Currency paid	How was payment made? (i.e.: check, credit card, cash)		
OTHER INSURANCE			
Is member covered by other insurance? <input type="checkbox"/> Y <input type="checkbox"/> N   If yes, number: _____			
If yes, name and address of carrier _____			
<b>Is the claim due to</b>			
an automobile accident? <input type="checkbox"/> Y <input type="checkbox"/> N   Please explain: _____			
any other type of accident? <input type="checkbox"/> Y <input type="checkbox"/> N   Please explain: _____			
the result of an occupational injury or illness? <input type="checkbox"/> Y <input type="checkbox"/> N			
Comments: _____			
SUBSCRIBER INFORMATION <input type="checkbox"/> Check if same as above.			
Subscriber's name			
Subscriber's address			
City, State, ZIP			
Home telephone (     )		Work telephone (     )	
AUTHORIZATION RELEASE			

I, the undersigned, hereby authorize any physician, hospital, insurer, or other organization or person having any medical or other records, data or information concerning me or my minor dependent to furnish such records, data or information to Fallon Health. I understand that in executing this authorization, I waive all claim and right of privilege with regard to such information. A photocopy of this authorization shall be considered as effective and valid as the original bearing my signature.

Subscriber signature \_\_\_\_\_ Date \_\_\_\_\_

Patient signature \_\_\_\_\_ Date \_\_\_\_\_  
 (if other than insured or minor)

*See reverse for instructions.*

# Instructions for submitting your Request for Payment of Medical Services

## Follow these easy steps:

1. **Check** the appropriate box showing that you want payment sent to the doctor or to you. If you want payment to go directly to you, **attach some proof of payment such as a canceled check (front and back) or paid receipt with a copy of your bank/credit card statement.** Remember to make a copy for your records.  
**For international claims:** If you paid cash, please include a copy of the source of the cash such as proof of wire transfer, traveler check receipt or your bank statement. All documentation must be in English.
2. **Complete** the "Member Information" section showing your name, member ID number and other identifying information.
3. **Complete** the "Physician or Provider of Service Information" section. Attach copies of itemized bills from the doctor or other provider. **Your request cannot be processed without the provider's NPI/tax ID number.** If this information is not on your receipt, please call the provider for this information.
4. **Complete** the "Other Insurance" section providing all information on other health insurance (if applicable), automobile accident, other accident or occupational illness/injury (workers' compensation).
5. **Sign and date** the Authorization Release.

**With complete information, payment will be received within 4–6 weeks.  
We will contact you in writing if we need additional information regarding your claim.**

**After completing the form, please mail or email it with receipts to:**

Fallon Health  
P.O. Box 211308  
Eagan, MN 55121-2908  
Email: [reimbursements@fallonhealth.org](mailto:reimbursements@fallonhealth.org)

**If you have any questions, please call Customer Service  
at the phone number on the back of your member ID card.**

To receive payment, forms must be submitted within one year of the date of service.

