HEALTH PLAN OF NEVADA
A UnitedHealthcare Company

Non-Plan Provider Claim Form
Member Instructions

IMPORTANT: Please review your applicable HPN Evidence or Agreement of Coverage for prior authorization requirements. If you choose to receive Covered Services that are not certified by HPN's Managed Care Program when using a Non-Plan Provider, you may be responsible for all costs.

WHAT THIS FORM IS FOR: This form is used whenever covered healthcare services are obtained from a Non-Plan Provider and a claim form must be filed with HPN in order that the Non-Plan Provider is paid for services rendered. After your Non-Plan Provider Claim Form has been submitted and accepted by HPN, you will be provided with a statement detailing the dollar amount applied to your annual Calendar Year Deductible and any applicable maximum benefit limit.

HOW TO FILE A CLAIM: Most Providers will bill HPN directly. Before you submit a Non-Plan Provider Claim Form to us, find out if it is necessary to do so. Many Providers will submit claims even if they are not contracted with HPN. This is why it is important to show your Member ID Card at each appointment. If you are asked by the Non-Plan Provider to submit the claim, please complete Section 1 only of the Non-Plan Provider Claim Form. The Non-Plan Provider must fill out Section 2 of the Non-Plan Provider Claim Form. Once the form is completed, please submit to HPN's Claims Department at the address provided below. Please include copies of any applicable itemized bills and/or receipts from the Non-Plan Provider. The Non-Plan Provider's itemized bill must include the following information:

- Name, Address, and Tax Identification Number;
- Date of Service;
- Diagnosis;
- Description of Services and/or standardized codes rendered; and
- Itemized charges for each service.

Items that will **not** be accepted for reimbursement include, but are not limited to:

- Billing statements indicating balance due; or
- Credit card receipts.

Completed Non-Plan Provider Claim Forms with copies of corresponding bills and/or receipts should be sent to:

Mailing Address
Health Plan of Nevada
Attn: Claims Department (2720-4)
P.O. Box 15645
Las Vegas, NV 89114-5645

Physical Address if Using Courier Services
Health Plan of Nevada
Attn: Claims Department (2720-4)
2720 N. Tenaya Way
Las Vegas, NV 89128-0424

Coordination of Benefits (COB): If HPN is your secondary healthcare carrier, we must receive a completed Non-Plan Provider Claim Form and a copy of the Explanation of Benefits (EOB) statement for the billed charges from your primary carrier in order to process your claim.

How Your Claim is Paid: If you authorize payment to the Non-Plan Provider, HPN will pay the Non-Plan Provider directly. If you do not authorize payment to the Non-Plan Provider, HPN will pay you directly and you will be responsible for payment to the Non-Plan Provider. HPN will provide you with an explanation of how the Non-Plan Provider's payment was determined.

For additional Non-Plan Provider Claim Forms: Please contact HPN's Member Services Department at (702) 242-7300 or 1-(800)-777-1840, Monday – Friday, 8:00 AM to 5:00 PM Pacific Standard Time.

PHOTOCOPIES OF THIS CLAIM FORM ARE NOT ACCEPTABLE

Member: Give this form to your Non-Plan Provider before obtaining benefits for Covered Services.
Provider: Certain Covered Services require Prior Authorization.

SECTION 1: Subscriber and Patient Information

1. Subscriber's Name (Please Print) _____
2. Subscriber's ID # (See ID Card) _____
3. Group # or Name (See ID Card) _____
4. Subscriber's Address _____
   _____
5. Subscriber's Date of Birth _____ Subscriber's Marital Status _____
6. Spouse's Name _____ Spouse's Employer _____
7. If you are still disabled, on what date do you expect to resume work? _____
8. If the patient is your enrolled Dependent and you are filing a claim, please include the following information:
   Dependent's Name _____
   Dependent's Date of Birth _____ Dependent's ID # (if known) _____
   Dependent's Address (if different from Subscriber) _____
   Is the Dependent employed? (Yes or No) _____ If yes, by whom? _____
9. Are any benefits provided or will they be provided under any other Health Benefit Plan for this claim? (Yes or No) _____ If yes, explain below:
   Other Employer _____ Other Healthcare Carrier _____
   ID # _____ Policy # _____ Group # _____
10. If you are enrolled in an Individual Plan, when were you or your Dependent first treated for this accident or sickness? _____
11. Is this claim the result of an auto accident? (Yes or No) _____ If yes, please provide date and place of incident _____
12. The statements above are true and correct to the best of my belief. I authorize any hospital or physician to furnish HPN or their authorized representative any information requested. Also, I hereby authorize any hospital or physician to furnish HPN or their authorized representative to release or obtain from any organization or persons any information which may be necessary to determine benefits payable under the Plan with HPN.

    Signed (Subscriber or Authorized Representative) _____ Date _____

    Patient/Dependent Signature (18 years and over) _____ Date _____
13. I authorize payment of medical benefits to the undersigned physician or supplier for service designated in Section 2.

    Signed (Subscriber or Authorized Representative) _____ Date _____

    Patient/Dependent Signature (18 years and over) _____ Date _____

SECTION 2: Physician or Supplier Information (Must be completed by Physician or Supplier)

14. DATE OF CURRENT: MM | DD | YY — ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM | DD | YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM | DD | YY FROM — MM | DD | YY TO

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM | DD | YY FROM — MM | DD | YY TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? ☐ YES ☐ NO — $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. ____ . __ 3. ____ . __

2. ____ . __ 4. ____ . __

22. MEDICAID RESUBMISSION CODE — ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1												
2												
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN EIN ☐ ☐

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ☐ YES ☐ NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

PIN# GRP#

PHYSICIAN OR SUPPLIER INFORMATION

WARNING: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company, penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Division of Insurance.

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