Independent Health Claim Form

Please fill out claim form completely. In addition to this claim form, you must submit proof of payment (such as a receipt) and an itemized bill. Any missing information may cause a delay in processing.

SECTION A – Please complete all of the following:

1. Patient's name ___________________________
2. IHA ID number with 2-digit suffix ____
3. Date of birth _____________________________
4. Address ______________________________ ____

SECTION B – Please complete all areas:

4. Name of referring physician or other source ____
5. Date of service(s) ___________________
6. Type of visit (check all that apply)

___Emergency room ___Laboratory ___Inpatient hospital ___Urgent care
___Outpatient hospital ___Dental ___Office visit ___Pharmacy
___Ambulance Other: ______________________

7. Provider information

Provider's full name _____________________
Address ________________________________
____
Phone number __________________________

8. Reason for visit and diagnosis

____
____
____
____

9. Is patient's condition related to:

a. Employment? (Current or Previous) ☐ Yes ☐ No
b. Auto accident? ☐ Yes ☐ No
c. Other accident? ☐ Yes ☐ No

SECTION C – For International Claims Only - Complete all areas:

1. Expected reimbursement _________
2. Type of currency used (ex: Canadian dollar) ____

AFFIRMATION: I hereby affirm that the above statements and information on the enclosed bills/receipts are complete and accurate to the best of my knowledge. I also agree to reimburse Independent Health to the extent of any overpayment which is in excess of the amounts payable

under my contract/riders (s). In addition, I hereby authorize Independent Health to obtain any information which may be necessary to determine benefits. A photocopy of this authorization will be valid.

Subscriber/Member Signature ________________________ Date Signed ________________

IMPORTANT! Proof of payment is required in order to be reimbursed for services. Proof of payment includes, but is not limited to, a valid cash register or credit card receipt, a signed document from the provider, or billing history showing a balance due of $0. Please note: If the charges total over $2,000, a copy of the credit card statement or bank statement showing the billed charges also needs to be included with the proof of payment to verify the paid charges.

- For medical claims, send completed claim form and proof of payment to:

  Independent Health Claims Department
  P.O. Box 9066
  Buffalo, NY 14231

- For pharmacy claims, send completed claim form and proof of payment to:

  Independent Health
  Attn: Pharmacy Claims
  P.O. Box 9066
  Buffalo, NY 14231

All claims will be processed according to the terms, conditions and exclusions of your contract.

If you have any questions about this form, please call our Member Services Department at (716) 631-8701 or 1-800-501-3439, Monday through Friday from 8 a.m. to 8 p.m.