KAISER PERMANENTE®

Kaiser Foundation
Health Plan of the Northwest

NON-PLAN CARE INFORMATION

Please complete this form in its entirety, attach all original bills and return to:

Kaiser Permanente Claims Administration
500 N.E. Multnomah Street, Suite 100 • Portland, OR 97232-2099
Portland area: (503) 813-2000 • All other areas: 1-800-813-2000

IMPORTANT: Incomplete forms will be returned to you for completion before processing.

ABOUT THE PATIENT/SUBSCRIBER

PATIENT'S NAME:			SEX: ☐ MALE ☐ FEMALE	BIRTHDATE: / /
PATIENT'S ADDRESS (STREET):			HEALTH RECORD NUMBER:	
CITY:	STATE:	ZIP CODE:	GROUP NUMBER:	
PATIENT'S DAYTIME PHONE NUMBER: ( )			MEDICARE? ☐ YES ☐ NO	
SUBSCRIBER'S NAME:	RELATION TO PATIENT:		SUBSCRIBER'S SOC. SEC. NUMBER:	
SUBSCRIBER'S ADDRESS (IF DIFFERENT FROM ABOVE):			SUBSCRIBER'S EMPLOYER:	
CITY:	STATE:	ZIP CODE:	EMPLOYER'S ADDRESS:	
SUBSCRIBER'S DAYTIME PHONE NUMBER: ( )			CITY:	STATE: ZIP CODE:

COMPLETE IF PATIENT IS COVERED BY OTHER INSURANCE

INSURANCE CO. NAME:	SUBSCRIBER'S NAME:
INSURANCE CO. ADDRESS:	SOCIAL SECURITY OR I.D. NUMBER:
INSURANCE CO. PHONE NUMBER: ( )	GROUP NUMBER:

ABOUT THE NON-PLAN CARE

LOCATION WHERE ILLNESS/INJURY OCCURRED:		INCIDENT DATE: / /	TIME: ☐ AM ☐ PM
DID YOU NOTIFY KAISER FOUNDATION HEALTH PLAN OF THE NORTHWEST **AT THE TIME THIS OCCURRED?** ☐ YES ☐ NO	WITH WHOM DID YOU SPEAK?	DATE: / /	TIME: ☐ AM ☐ PM
PLACE OF EMERGENCY CARE:		DATE: / /	TIME: ☐ AM ☐ PM

WAS AN AMBULANCE USED?	☐ YES ☐ NO	IF YES, WHO CALLED THE AMBULANCE?	NAME OF AMBULANCE CO:
		IF NO, WHO TOOK THE PATIENT FOR TREATMENT?	
IF HOSPITALIZED	ADMIT DATE: / /	HOSPITAL NAME:	
	DISCHARGE DATE: / /	HOSPITAL ADDRESS:	
WAS FOLLOW-UP CARE RECEIVED?	☐ YES ☐ NO	IF YES, NAME OF PROVIDER:	
		DATE(S) FOLLOW-UP CARE RECEIVED:	

DESCRIBE IN DETAIL CARE RECEIVED. PLEASE INCLUDE WHY THE PATIENT WAS NOT TREATED AT A KAISER PERMANENTE FACILITY.

I CERTIFY THAT THE INFORMATION PROVIDED ON THIS FORM IS CORRECT TO THE BEST OF MY KNOWLEDGE. I AUTHORIZE THE RELEASE OF ANY AND ALL INFORMATION NECESSARY TO PROCESS THIS CLAIM INCLUDING MEDICAL AND/OR HOSPITAL RECORDS TO KAISER FOUNDATION HEALTH PLAN.

PATIENT'S SIGNATURE (PARENT'S SIGNATURE IF THE PATIENT IS A MINOR) X	DATE SIGNED: / /

IF CARE WAS WORK RELATED OR WAS THE RESULT OF AN ACCIDENT, COMPLETE THE REVERSE SIDE OF THIS FORM.

COMPLETE THIS SECTION IF ILLNESS/INJURY WAS WORK RELATED OR THE RESULT OF AN ACCIDENT

WAS THE ILLNESS/INJURY WORK RELATED? ☐ YES ☐ NO	EMPLOYER'S NAME:
HAS A WORKER'S COMPENSATION CLAIM BEEN FILED? ☐ YES ☐ NO	(PLEASE ATTACH EXPLANATION OF PAYMENT OR DENIAL FROM THE WORKER'S COMPENSATION CARRIER)
WAS INJURY DUE TO A MOTOR VEHICLE ACCIDENT? ☐ YES ☐ NO	(IF YES, PLEASE ATTACH COPY OF POLICE REPORT)
IF MOTORCYCLE ACCIDENT, DO YOU HAVE MEDICAL COVERAGE AS PART OF YOUR MOTOR VEHICLE INSURANCE COVERAGE? ☐ YES ☐ NO	
WERE OTHER MEMBERS OF YOUR FAMILY INJURED? ☐ YES ☐ NO	
HAVE YOU FILED A CLAIM WITH YOUR VEHICLE INSURANCE CARRIER FOR MEDICAL PAYMENTS? ☐ YES ☐ NO	IF YES, PLEASE ATTACH EXPLANATION OF PAYMENT OR DENIAL. IF NO, PLEASE SUBMIT YOUR CLAIM TO THEM.
CARRIER'S NAME AND ADDRESS:	
POLICY NUMBER:	THIS POLICY IS FOR: ☐ SUBSCRIBER ☐ DEPENDENT ☐ OTHER:_____
WAS THE INJURY CAUSED BY SOMEONE ELSE? ☐ YES ☐ NO	**IF YES, READ AND COMPLETE THE REMAINDER OF THE EMERGENCY CARE CLAIM FORM AND SIGN THE TRUST AGREEMENT.**
NAME OF RESPONSIBLE PARTY: (I.E., HOMEOWNER, AUTO, PROPERTY, BOAT INSURANCE)	POLICY NUMBER:

PARTY'S INSURANCE COMPANY NAME:	STREET:	CITY:	STATE:	ZIP CODE:

If you have retained an attorney, please give the attorney's name, address and phone number.

ATTORNEY'S NAME:		PHONE: ( )	
STREET:	CITY:	STATE:	ZIP CODE:

IMPORTANT NOTICE

LIMITATION ON THIRD PARTY AND AUTOMOBILE RELATED INJURIES

Your Kaiser Foundation Health Plan (aka "Medical and Hospital Service Agreement") ("PLAN") does not cover medical or health care services which might be required because of (i) the act or omission of a third party; (ii) a private passenger motor vehicle accident, or (iii) an accident incurred or alleged to have occurred on the premises of a third party. The PLAN is not obligated to reimburse non-Kaiser Permanente providers until all third-party actions are settled or resolved. It is the member's responsibility to bill any other insurance carrier(s) or third parties and to demonstrate to PLAN officials that all reasonable efforts for recovery have been made.

TRUST AGREEMENT FOR THIRD PARTY AND AUTOMOBILE RELATED INJURIES

Although not obligated to reimburse non-Kaiser Permanente providers until all third-party actions are resolved, the PLAN may make payments to such providers prior to resolution as long as the member agrees to the following trust agreement.

To: Kaiser Foundation Health Plan of the Northwest

I understand the terms of my Medical and Hospital Services Agreement with Kaiser Foundation Health Plan of the Northwest or any of its affiliated organizations ("HEALTH PLAN") limit coverage for third party and automobile related injuries as stated above. In consideration of payment by HEALTH PLAN for medical or health care services received related to such third party or automobile injuries, I agree to pay HEALTH PLAN an amount equal to the total amounts paid and amounts to be paid by HEALTH PLAN for third party or automobile injury related services out of any recovery received for such injuries. Recovery includes, but is not limited to, settlements or awards from any administrative body, arbitration panel, court, employer, insurer, or self-funded insurance program less a proportionate share of attorney's fees (if any) incurred in obtaining the recovery. I further agree to hold any monies so recovered in trust for HEALTH PLAN; provided, however, that any sum recovered in excess of the total amount owed to HEALTH PLAN may be retained by me.

I agree that I have not released or discharged any claim against any third party or motor vehicle insurance company.

I further agree to notify HEALTH PLAN of any and all pending negotiations prior to settlement of my claim(s).

PATIENT'S SIGNATURE (PARENT'S SIGNATURE IF THE PATIENT IS A MINOR)	DATE SIGNED:
X	/ /