Your claim must be submitted within 180 days of the date you received notice

CLAIM FORM FOR KAISER PERMANENTE OUT-OF-NETWORK MENTAL HEALTH/ SUBSTANCE USE DISORDER SERVICES

Kaiser Permanente

Please note: This claim form is for certain claims described at www.OutofNetworkHealthClaims.com. To submit claims to Kaiser Permanente for other reasons, visit kp.org or call the number on your membership card.

GENERAL INSTRUCTIONS

This claims submission process is for California Kaiser Permanente members who attempted to, but could not access in-network mental health or substance use disorder services, and as a result paid for out-of-network care. If you (1) received out-of-network mental health or substance use disorder care after January 1, 2021, (2) were a Kaiser Permanente member in California at the time you received the out-of-network care, and (3) paid for (or are currently obligated to pay for) such care out of pocket, you may be eligible for reimbursement of some or all of your out-of-pocket costs. If you choose to submit a claim, you will need to complete the form below. You can submit the form online or mail it to Kaiser Permanente Notice Administrator, 1650 Arch Street, Suite 2210, Philadelphia, PA 19103. For additional information, please go to www.OutofNetworkHealthClaims.com.

I. MEMBER NAME AND CONTACT INFORMATION

Provide your name and contact information below. You must notify the Claims Administrator if your contact information changes after you submit this form.

First Name

Last Name

Street Address (Residence)

City

State

Zip Code

Email Address

Date of Birth

Membership Record Number

Region (NorCal/SoCal)

☐ My mailing address is different than my street address.

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Street Address (Mailing)

City **State** **Zip**

☐ I am submitting a claim for this member, who has passed away. ***Please fill out Addendum 1.***

Please enclose a copy of a document certifying the member's death (e.g., death certificate), as well as any document establishing your authorization to act on behalf of the deceased (e.g., letters of administration).

☐ I affirm that the member for whom this claim is submitted is deceased, and that I am authorized to submit this claim on the member's behalf.

☐ I am submitting a claim for a minor. ***Please fill out Addendum 1.***

☐ I affirm that I am the member's legal guardian.

☐ I am submitting a claim for an incapacitated adult member. ***Please fill out Addendum 1.***

Please enclose a copy of a document certifying the member's incapacity and your representative capacity (e.g., guardian of the estate or power of attorney), as well as any document establishing your authorization to act on behalf of the deceased (e.g., letters of appointment).

☐ I affirm that I am the member's court-appointed legal guardian or guardian of the member's estate, or have a valid power of attorney.

II. CLAIM INFORMATION

1. Did you receive out-of-network mental health/substance use disorder services and pay (or are obligated to pay) out of pocket for such services?

   ☐ Yes

   ☐ No

2. Before you received out-of-network mental health/substance use disorder services, did you attempt to obtain in-network services from Kaiser Permanente?

   ☐ Yes

   ☐ No

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3. Please describe your attempts to obtain in-network care before going to an out-of-network provider, including when you requested services, how you made the request (e.g., by phone, in-person, online), and to whom you made the request.

4. Please provide the following information for each out-of-network provider from whom you received mental health/substance use disorder services and paid (or are obligated to pay) for such services. If you received services from more than one provider, please use the space(s) provided at the end of this claim form to provide information related to those providers:

a. Provider Name: _____

b. Provider Phone Number: _____

c. Provider Email: _____

d. Number of visits with this provider for which reimbursement is requested: ☐

e. Date(s) of Service: _____ ☐

If you have more than ten (10) dates of service, instead of listing them, you may check this box and enclose documents that clearly show all dates of service for which you are seeking reimbursement.

f. Total amount you paid out of pocket for these services: _____

g. Total amount unpaid and owed for these services: _____

By submitting this claim, you affirm that you owe the amount stated. Kaiser Permanente may contact your provider to confirm whether the amount is owed. I agree to provide an authorization for the release of information if necessary.

h. Have you previously submitted a claim to Kaiser Permanente for reimbursement of your payments to this provider?

☐ Yes

☐ No

i. Are you receiving ongoing care from this provider?

☐ Yes

☐ No

III. DOCUMENTATION OF CLAIM – INVOICES OR ITEMIZED BILLS, AND PROOF OF PAYMENT

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1. Please enclose copies of the invoices or itemized bills for which you are seeking reimbursement. The documents must show the dates of services, services provided, and amounts billed. If you do not have documents in your possession that contain this information, you may be able to obtain them from your provider.

   ☐ I have enclosed the invoices or itemized bills for which I am seeking reimbursement.

   ☐ I provided these documents in connection with a previous reimbursement claim.

2. Please enclose copies of documents showing that you paid for the services. Acceptable documents include receipts, acknowledgements of payment, cancelled checks, and similar documents. If you do not have documents in your possession that show you paid the amounts for which you are seeking reimbursement, you may be able to obtain payment records from your provider.

   ☐ I have enclosed copies of documents showing that I paid for the services.

   ☐ I provided these documents in connection with a previous reimbursement claim.

   ☐ I am obligated to pay but have not yet paid for some or all of these services.

3. Please enclose any other documents you would like Kaiser Permanente to consider.

IV. ATTESTATION & SIGNATURE

I affirm that all the information I provided in this submission is true and accurate to the best of my knowledge, and that the documents I enclosed are authentic. I consent to Kaiser Foundation Health Plan, Inc. reviewing the documents that I have enclosed for the purpose of adjudicating my claim. I further consent to the Kaiser Permanente Notice Administrator accessing the documents for their submission to Kaiser Foundation Health Plan, Inc. I understand that I may need to provide written authorization to Kaiser Foundation Health Plan, Inc. for the release of medical records and I agree to provide written authorization for the release of those records to Kaiser Foundation Health Plan, Inc. I further understand that if my claim is approved and I accept the reimbursement Kaiser Foundation Health Plan, Inc. provides, I will not have any right to seek additional reimbursement for the services identified in my claim.

Signature	Printed Name	Date

V. CLAIM INFORMATION – ADDITIONAL PROVIDERS

4. Please provide the following information for each out-of-network provider from whom you received and paid for mental health/substance use disorder services:

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a. Provider Name: _____

b. Provider Phone Number: _____

c. Provider Email: _____

d. Number of visits with this provider for which reimbursement is requested: ☐

e. Date(s) of Service: _____ ☐

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h. Have you previously submitted a claim to Kaiser Permanente for reimbursement of your payments to this provider?

☐ Yes

☐ No

i. Are you receiving ongoing care from this provider?

☐ Yes

☐ No

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ADDENDUM 1 (DECEASED, MINOR, OR INCAPACITATED MEMBERS)

Relationship to Member

First Name

Last Name

Street Address (Residence)

City

State

Zip Code

Email Address

Phone