Relation™

Relation Insurance Administrators
P.O. Box 6040
Agoura Hills, CA 91376-6040

CLAIM FORM

PLEASE COMPLETE IN FULL TO ENSURE PROPER PROCESSING

NAME OF GROUP Intercultural Exchange Group Medical Insurance	POLICY NUMBER 0863963-010-100		
PARTICIPANT'S LAST NAME	PARTICIPANT'S FIRST NAME		MI
PARTICIPANT'S U.S. MAILING ADDRESS—NUMBER AND STREET NAME (OR P.O. BOX #), CITY, STATE, ZIP			
PARTICIPANT'S DATE OF BIRTH (MM/DD/YY) ☐ FEMALE ☐ MALE	PARTICIPANT'S ID NUMBER Member #:	PARTICIPANT'S PHONE NUMBER	

If patient is a Dependent currently insured under this plan, complete information below (in addition to the above).

PATIENT'S LAST NAME	PATIENT'S FIRST NAME	MI
PATIENT'S U.S. MAILING ADDRESS —NUMBER AND STREET NAME (OR P.O. BOX #), CITY, STATE, ZIP		
PATIENT'S DATE OF BIRTH (MM/DD/YY) ☐ FEMALE ☐ MALE	PATIENT'S PHONE NUMBER	

SECTION 1 – TYPE OF CLAIM

1. Is this claim pertaining to a sickness/medical condition or an injury (which may include prescription medication), or for prescription reimbursement only?
   - ☑ Prescription Reimbursement Only. Please complete **SECTION 4** and **SECTION 5**.
   - ☐ Sickness/medical condition. Please complete **SECTION 3**, **SECTION 4**, and **SECTION 5**.
   - ☐ Injury. Please complete **SECTION 2**, **SECTION 4**, and **SECTION 5**.

SECTION 2 – INJURY INFORMATION

2. Date that injury occurred: ______________________ When was physician first consulted? ______________________
3. Briefly describe the type of injury (i.e., ankle sprain, broken arm, etc.) and how and where the injury occurred:
4. Was the injury the result of a motor vehicle accident? ☐ No ☐ Yes
5. Did the injury occur while at your place of work? ☐ No ☐ Yes If yes, please list the name and address of the employer:
____

SECTION 3 – SICKNESS INFORMATION

6. Briefly describe the sickness or medical condition: ______________________
7. Have you suffered the same or similar condition before? ☐ No ☐ Yes If yes, and you were previously treated for it, date treated: ______________
   Name and address of physician who treated you: ______________________
8. If hospitalized at that time, date confined to hospital: ______________________
   Name and address of hospital: ______________________

SECTION 4 – OTHER INSURANCE INFORMATION

9. Do you have *other* insurance which covers your condition (group, individual, automobile, medical, or liability)? ☑ No ☐ Yes
   If yes, who is the Policyholder? ☐ Self ☐ Parent ☐ Spouse Name of Insurance Carrier: ______________________
   Member No.: ______________ Group No.: ______________ Insurance Co. Phone No.: ______________
   Primary Insured's Name (Parent/Spouse): ______________________

SECTION 5 – ASSIGNMENT OF BENEFITS

10. Indicate below to whom payment is to be made:
    - ☐ Balance is owed to the provider of service. Please pay the provider as indicated on billing statement.
    - ☑ Expenses have been paid by the patient/participant. Please reimburse the patient/participant listed above.

AUTHORIZATION TO RELEASE INFORMATION: To any medical care provider, medical care facility, insurer, government-sponsored health plan, or employer, I permit (while my claim is pending) the release of any medical information about me to the Company and its representatives. The Company's representatives include reinsuring companies and other persons or groups performing business of legal services relating to my claim. This applies to all information about the diagnosis, treatment, or prognosis or any illness or injury I now have or have had in the past. The Company will use this information to find out if my claim is eligible. A copy of this authorization (one of which will be given to me by the Company upon my request) will be as valid as this one. I certify that the above information given by me in support of this claim is true and correct.

Patient's or Participant's Signature______________________________ Date ______________

IMPORTANT: This form must be completed and returned to the company within 60 days from the date of treatment, accompanied by all bills incurred to that date. Please include itemized bills (see itemized bill requirements on page 2).

PLEASE SUBMIT THIS COMPLETED FORM BY MAIL TO: Relation Insurance Administrators, P.O. Box 6040, Agoura Hills, CA 91376-6040

CLAIMS PROCESS

1. After you receive treatment at a PPO provider, the provider will usually submit the charges directly to the claims administrator for you. In this case, you will receive an Explanation of Benefits indicating what the insurance covered. The provider will then bill you for any remaining charges, such as your coinsurance amount. *You do not need to send balance billing statement (after the insurance has paid) for reimbursement, as that is your responsibility to pay.*

2. If you are asked to pay up front for medical treatment you receive, or if the provider does not send the claim to the claims administrator, you will need to submit a claim for the portion of the charges for which the company is responsible. Submit **itemized hospital and medical bills with a completed claim form to**:

   Relation Insurance Administrators
   P.O. Box 6040
   Agoura Hills, CA 91376-6040
   Fax: (818) 735-3567

3. If you fill a prescription, you must pay in full at the time of pick up. You will then need to submit a claim for reimbursement for the portion of the charges for which the company is responsible. Submit the **itemized prescription drug receipt** with a completed claim form to:

   Relation Insurance Administrators
   P.O. Box 6040
   Agoura Hills, CA 91376-6040

4. If you have questions regarding your claim submission, please send an email to **riainfo@relationinsurance.com**.

5. If you have questions about the status of your claim after it has been submitted or for any questions about benefits, please call Relation Insurance Administrators at **(800) 314-3938**, Monday–Friday, 6:30 a.m. to 5:00 p.m. (4:00 p.m. on Fridays) PT.

   Always keep a copy of all documents submitted for claims.

ITEMIZED BILL REQUIREMENTS

Hospital and Medical Bills

A fully itemized billing statement is required for claims payment consideration. The itemized billing statement must include the following:

- Patient's name
- Patient's date of birth
- Provider's name
- Provider's address
- Provider's tax identification number
- Diagnosis code(s)
- Date of service
- Procedure code(s)
- Amount charged for each procedure

Note: If your billing statement does not include this information, please contact the provider and ask them to send a copy to you to include with this form. (The fully itemized billing form is also known as a HCFA 1500, CMS 1500, UB04, and CMS 1450.)

Prescription Drug Receipts

A fully itemized prescription drug receipt is required for claims payment consideration. The prescription drug receipt must include:

- Pharmacy name
- Prescription (Rx) number
- Patient's name
- Name of the medication(s)
- Prescribing physician's name
- Dosage or quantity dispensed
- NDC code number
- Date of service
- Amount charged

Note: Please do not send a cash register receipt listing only the charges. You must send the full receipt or print-out that includes all of the above.

If you (or the medical provider) do not provide the Rx receipt as indicated above, your claim may be denied until the information is provided.