Submitting a Reimbursement Claim

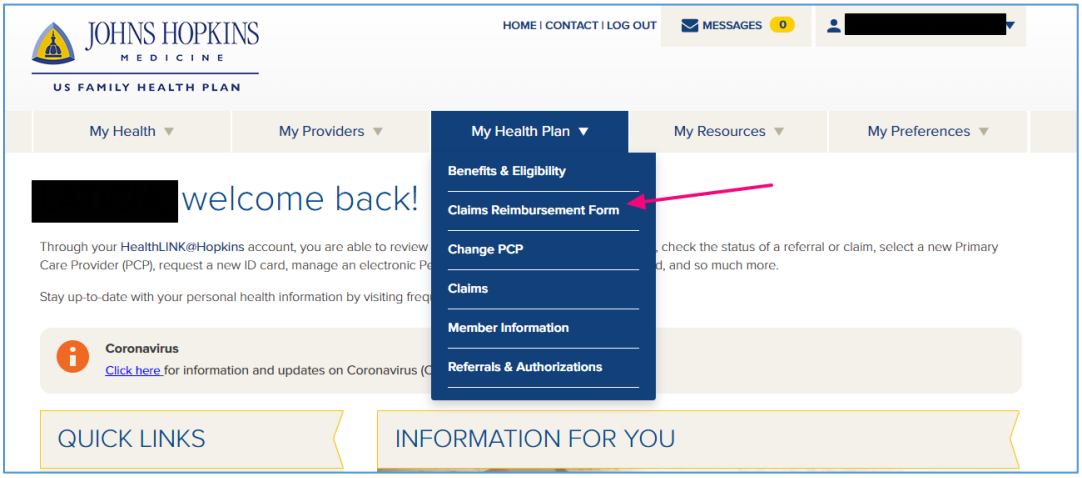
For USFHP

Follow the steps below to complete a Reimbursement Claims Form. Be sure to enter in all the required information and attach proof of payment information to ensure timely processing.

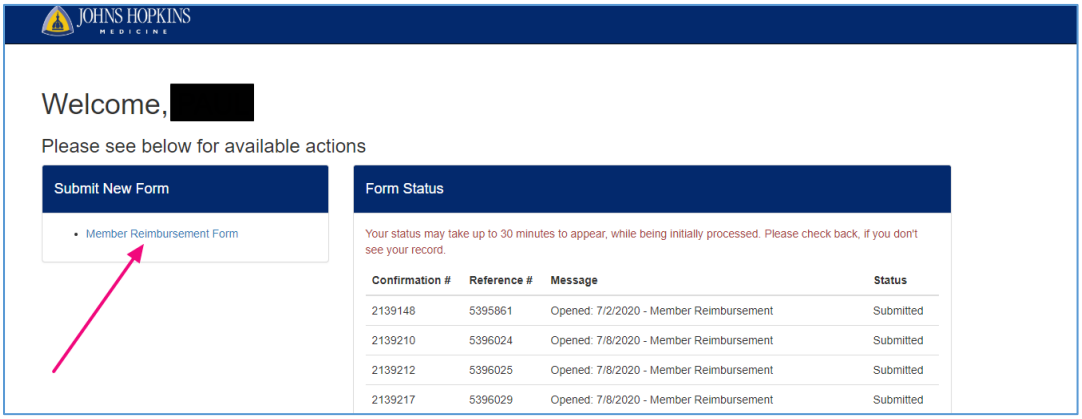
Steps

1. Log into your HealthLINK member portal. (If you do not already have an account, click the Member Register button under "First Time Logging In?")

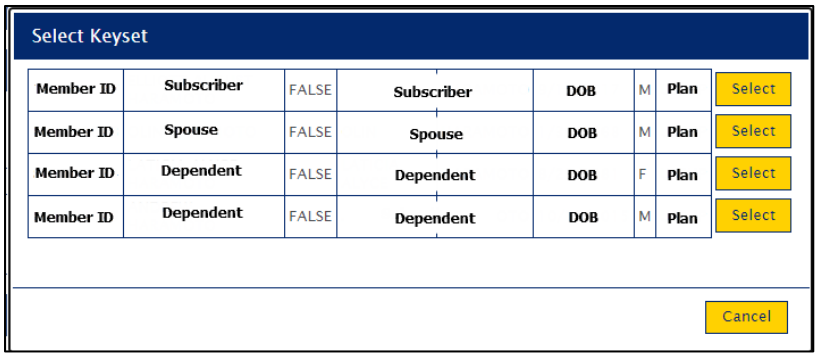
2. Once inside your member portal, go to the "My Health Plan" menu and select "**Claims Reimbursement Form.**"



3. Select the "Member Reimbursement Form" link. Note: You can also check the status of previously submitted claims on this page.



4. If you have dependents on your account, a window with the dependents will show. Select the appropriate member.



5. In the Claims Reimbursement Form, fill out all the required fields and include any supplemental information. Add your proof of payment as an attachment.

Resource

The table below contains the fields and descriptions found on the Claims Reimbursement Form. You may find it helpful to reference this chart as you fill out the form.

Form Field	Description
1. Member Information	**For whom is this claim being submitted?**
The member information is auto-populated based upon the selected member, (single member or selected member from the list of covered family members). If you select the wrong member from the list of covered family members, selecting 'Clear Member Detail' will return you to the selection grid.	
Member ID	Auto Populated: ID# from the insurance card of the insured.
First Name	Auto Populated: Member's First name as shown on the insurance card
Last Name	Auto Populated: Member's Last name as shown on the insurance card
Health Plan	Auto Populated: Member's Health Plan based upon selected member
Date of Birth	Auto Populated: Member's date of birth
2. Member Information	
Was Patient's Care:	Select whether the reimbursement is for inpatient, outpatient, or day surgery.
Patient's Relationship to Sponsor	What is the relationship of the patient to the sponsor?
Daytime Phone	
Evening Phone	
Sponsor's Name	Required if 'Self' is NOT selected for the 'Patient's Relationship to Sponsor' field. *(field will not show on the form unless an option other than 'Self' is selected for Patient's Relationship to Sponsor)*
Country Services were Rendered	Which country was the care was received in
3. Requestor Information	
Requestor Name	Auto Populated: Name of individual completing the form (for contact purposes)
4. Claim Information	
Provider's Tax ID	Optional
Group/Provider Name	Required: Name of the provider or facility where the service was performed

Provider NPI#	Optional
Patient Account#	Optional
Provider Address Line 1	Optional: Address where the service was performed
Provider Address Line 2	
City, State, Zip	
5. Service Lines	**Enter each individual procedure as documented on the bill. Add lines as needed.**
Date of Service	The date the service was provided
Billed Amount	The amount billed by the provider or facility
Procedure Code or Description	The procedure code or description of the service provided
Diagnosis Code or Description	The diagnosis code or description relating to the service provided
Number of Service Lines	Auto Populated with the number of service lines on the form
Amount Paid	The amount paid to the provider to date.
Total Charge	Auto Populated with the sum of all billed amounts entered.
6. Attachments	
Click to upload an attachment	Optional; allows you to select an attachment to upload
Click to Sign Document	This is required as you must enter your signature to certify that, to the best of your knowledge, all the information is valid and correct.