Member Claim Form

2650 Novation Parkway • Fitchburg, WI 53713
(800) 362-3310 • Fax (608) 643-2564
QuartzBenefits.com

If you have paid for covered medical services and the provider **WILL NOT** be submitting claims to Quartz, please complete this form. This includes services you may have received in a foreign country. *All sections of this form and the appropriate documentation must be submitted for Quartz to process for reimbursement.*

Important information

- Do not include prescriptions on this form. Visit QuartzBenefits.com/memberforms and go to the Forms section to find the Member Reimbursement Form (direct member Reimbursement Form for medications). Do not file any other medical or pharmacy reimbursements on this form.
- If you are submitting this form for out-of-network hearing aid reimbursement, please submit the model number and manufacturer name on this form or on the proof of purchase document.
- Complete a separate form for each covered family member.
- Do not file a claim if the provider is filing for the same services. (Note: if the provider is contracted with Quartz, reimbursement will be paid to the provider and the member is responsible for getting reimbursement from the provider.)
- Claims typically must be filed within 12 months from the date of service or as otherwise required by your Certificate of Coverage or benefit brochure. Claims not filed within the time frame must have proof that timely filing was prevented by administrative operations of government or legal incapacity.
- Quartz processes claims within 30 days of receipt. The reimbursement check will be made out to and sent to the policyholder of the health plan.

Section 1: Member information

Patient information		
Patient information		
Member ID number		
Last name	First name	Date of birth *(mm/dd/yyyy)* ___/___/_____
Subscriber information		
Subscriber ID number		
Last name	First name	Date of birth *(mm/dd/yyyy)* ___/___/_____

Section 2: Medical services

Date of service	Place of service *For example: Urgent Care, Emergency Room, Office Visit, Inpatient Stay, etc.*	Description of service	Amount billed	Amount paid

Section 3: Documentation

Attach **ALL** of the following pieces of documentation:

- **Itemized Bill of Services or Primary Insurance Explanation of Benefits (if applicable)**
  From the provider/insurer that indicates:
  - Date of service
  - Procedure codes
  - Diagnosis codes
  - Amount billed
  - Amount paid
  - Copy of all documents received from foreign providers (if applicable)
  - Model number and manufacturer name for hearing aid (if applicable)

- **Proof of Payment**
  If paid by:
  - *Check*: Submit a copy of cancelled check(s), front and back
  - *Credit card*: Submit a copy of the original credit card receipt, emailed Square receipt or the credit card statement showing charges (blackout all other information on the credit card statement)
  - *Cash*: Receipt on provider letterhead showing paid cash, including amount billed and paid

Important: If the amount on the Itemized Bill of Services **does not match** the Proof of Payment, you must explain why before we can provide reimbursement.

Once this form is complete and the appropriate documentation is attached, submit it to us by using one of these options:

Fax: **(608) 643-2564**

Mail: Attn: Claims
Quartz
P.O. Box 211221
Eagan, MN 55121