PARAMOUNT MEMBER SUBMITTED CLAIM PROGRAM

In order to process your request for reimbursements in a timely manner, **Paramount must receive specific information for claims processing**. Incomplete information will delay processing of your reimbursement check. A description of reimbursement coverage is provided in your *Summary of Benefits* and *Evidence of Coverage* member handbooks. Please follow the step-by-step instructions for all required fields to ensure your reimbursement can be processed promptly. Thank you.

Should you have any questions regarding your reimbursement, please contact:

Member Services Department,
Telephone: 419-887-2525
TTY for Hearing Impaired: 1-888-740-5670 (toll-free)
Hours: 8 a.m. to 8 p.m. Monday – Friday.
From October 15 through March 1 we are available 8:00 a.m. to 8:00 p.m. seven days per week.

Not Acceptable –

YOUR REQUEST WILL BE RETURNED FOR ADDITIONAL INFORMATION IF SUBMITTED:

- Handwritten notation of payment on statement without proof.
- Copies of bills without proof of payment included.
- Previous balance statements with no itemization charges.
- Provider is participating with Paramount
- Bill and/or receipt not legible
- Provider tax information

Please ask your provider to assist you in completing Section II of the reimbursement form or submit a completed HCFA 1500 form and attach your paid receipt. Submit completed forms to the address provided below. If no HCFA 1500 form is attached, sections I and II must be completed in their entirety by you and your provider.

***Not intended for use on claims billed on UB04 for facility services.**

Thank You

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PARAMOUNT REIMBURSEMENT FORM

I. MEMBER INFORMATION AND SIGNATURE

By submitting this claim form, I (participant named below) request reimbursement from Paramount as listed below. I certify these are eligible expenses I have incurred and have attached proof of payment. Please pay me directly.

Patient Name ______________________________ ID # ____________

Address ______________________________

City/State ______________________________ Zip ____________

Signature ______________________________ Date ____________

Do you have other medical coverage? Yes ______ No ______

If yes, please attach a copy of your other policy's **Explanation of Benefits** which shows the amount they have paid for the same services. You can only receive a reimbursement for covered services that have not been paid for by another policy.

FOR PROVIDER USE ONLY:

The below information must be completed to ensure accuracy and timely review for payment, subject to benefit limitations of your plan. You can substitute a completed **HCFA 1500 form** or itemized statement with completed description of services below.

II. DESCRIPTION OF SERVICES

Date of Service	Location Code	Diagnosis Code	Procedure Code	Description of Services	Billed Amount

Provider Certification/Verification – MUST HAVE W9 TAX INFORMATION

I certify the patient named above incurred these expenses.

Provider Name______________________ NPI/Tax ID#______________________

Address______________________City____________State________Zip________

Check Where Applicable: Reimburse Provider ________ Reimburse Member ________

Provider Signature______________________________Date______________

Please mail your reimbursement request to:

Reimbursement Processing
P.O. Box 928
Toledo, OH 43697-0928