Medical and/or Dental Need Reimbursement Form

Patient Info			
Name:	M.I.:	Last Name:	
Mailing Address:		City:	
State:	Zip:	Phone Number:	
Patient Gender:		Patient Date of Birth**:**	
Member ID #:		Payor #:	Group #:
Patient's Relationship to Primary Member: **Self** / **Spouse** / **Dependent**			
Member's Effective Date:		Program Name:	

Provider Info			
Provider Full Name:		Provider Tax Id #:	
NPI Number (10 digit #):		Group/Facility Name:	
Address:		City:	
State:	Zip:	Phone Number:	

Select one of the following Types of Service below:

Injury: Date of Service	____ / ____ / 20____	**Dental:** Visit Date	____ / ____ / 20____
Pregnancy: Date of Service	____ / ____ / 20____	**Wellness:** Date of Service	____ / ____ / 20____
Office Visit: Visit Date	____ / ____ / 20____	**Other Type:** Date of Visit	____ / ____ / 20____

Please provided a brief overview for the reason of the visit for you or your family member.

Please provide one of the following forms:
UB04 or HCFA1500 or "Superbill"-provides Procedure Codes (CPT), Diagnosis Codes (ICD-10), Modifiers, additional pieces of data to avoid need denial. We will need the Date of Service, Procedure Codes & Description (CPT), Diagnosis Codes / Description (ICD-10 or ICD-9) Modifiers (if applicable), Units or Minutes to indicate count / number of units for given code, Fees Charged, and Receipts.

Signature:
By signing below, I am stating all information herein is correct. I realize any person who knowingly sumbits a medical and/or dental need reimbursement containing any misrepresentation or any false, incomplete, or misleading information may have their JHS Community membership cancelled.

Member's Signature: X _____ Date: _____ / _____ / _____

Only eligible medical and/or dental needs that have a proof of payment will be shared directly to the member. Otherwise, eligible needs will be shared directly to the billing provider. Please SUBMIT using ONE of the below options:

Mail To: JHS Community / Medical and Dental Needs P.O. Box 21272, Eagan, MN 55121

Email to: providerservices@jhscommunity.org

Fax to: 866-443-7563