TakeCare
P.O. Box 6578 Tamuning, Guam 96931
Telephone: (671) 647-3526
Fax: (671) 647-3542

OFFICIAL USE:
Customer Service Representative Name & Initial
RECEIVED

OFFICIAL USE:
Claims Representative Name & Initial
RECEIVED

Deductible, Reimbursement and Out-of-Pocket Maximum Member Claim Form

MEMBER/PATIENT INFORMATION

Last Name: | First Name: | MI:

ID: | DOB:

Home Telephone: | Work Telephone: | Other:

☐ Check will be mailed to current address on file

☐ Check will be picked up by Member or authorized representative (ID required)

Member's relation to subscriber ☐ Subscriber ☐ Spouse ☐ Child ☐ Other _____

SUBSCRIBER INFORMATION

Last Name: | First Name: | MI:

ID: | DOB:

UPDATED INSURANCE INFORMATION

Primary ID#:

Primary Carrier:

☐ NetCare ☐ SelectCare ☐ StayWell
☐ TakeCare ☐ MediCare
☐ Other

Subscriber Name:

Subscriber DOB: | Relationship:

Secondary ID#:

Secondary Carrier:

☐ NetCare ☐ SelectCare ☐ StayWell
☐ TakeCare ☐ MediCare
☐ Other

Subscriber Name:

Subscriber DOB: | Relationship:

Member Initials

TakeCare Representative Initials

Page 2 must be completed.

TakeCare

Deductible, Reimbursement Out-of-Pocket Maximum Member Claim Form

REQUIREMENTS (when applicable)

Outpatient Medical	Inpatient Medical	Pharmacy	Dental	PI Travel
Provider name	Provider name	Pharmacy name	Provider name	Business name
Provider contact info	Provider contact info	Pharmacy contact info	Provider contact info	Business contact info
Provider W-9 tax form	Provider W-9 tax form	Prescribing physician	Provider W-9 tax form	Date(s) of service
Date(s) of service	Date(s) of service	Prescription slip (outside the US)	Date(s) of service	Pertinent medical records
Diagnosis (ICD) code(s)	Diagnosis (ICD) code(s)	Fill date(s)	Procedure (CDT) codes	Airline itinerary
Procedure (CPT) code(s) & modifiers	Revenue code(s)	Medication Name	Quad/tooth/surface	Airline boarding pass
Itemized billed charges	Itemized billed charges	NDC#	Itemized billed charges	Official Lodging info
Pertinent medical records	Pertinent medical records	Dosage/quantity	Treatment plan	Lodging dates
Official proof of payment	Official proof of payment	Pertinent medical records	Pertinent dental records	Official proof of payment
Travel document (if applicable)	Travel document (if applicable)	Official proof of payment	Official proof of payment	Notice of Benefit Eligibility
Explanations of benefits	Explanations of benefits	Travel document (if applicable)	Travel document (if applicable)	Deductible and Out-of-Pocket Maximum
*If injury from an accident - Cause and Place of accident and Police report	UB04 Claim Form	Explanation of benefits	Explanation of benefits	UB04 or HCFA Form/CMS 1500 Original Receipts
	*If injury from an accident - Cause and Place of accident and Police report			

CLAIM INFORMATION

Provider/Pharmacy/Airline/Lodging Name	Date(s) From	Thru	Paid Amount	Official Use

Claim forms for reimbursement must be submitted no later than ninety (90) days from the date of service. Claim forms for deductibles and out-of-pocket maximums must be submitted no later than ninety (90) days from the date the deductible or out-of-pocket maximum is met. Claim forms must include all original receipts and all required documentation stated above. All claims will be processed based on eligible charges for Participating and Non-Participating Providers. You are responsible for any excess charges over eligible charges. TakeCare will not process any claim forms or supporting documentation submitted in a foreign language unless the documentation is translated to English. Reimbursements are generally issued within thirty (30) business days from receipt of a completed claim form and supporting documentation.

ACKNOWLEDGMENT & AUTHORIZATION

I hereby certify that the above information is true, accurate and complete. I acknowledge that this claim form, and all required documentation, must be submitted as provided in the above Requirements section. The failure to timely submit claim forms will result in expenses not being covered. I understand that all claims will be processed based on eligible charges for Participating and Non-Participating Providers. I also understand that my claim(s) may be delayed and/or denied if any requirements are not submitted timely or in compliance with the above Requirements section. Further, I authorize the release of any protected health information required by TakeCare to process my claim(s).

Member Name/Signature

Date Signed

TakeCare Service Representative Name/Signature/Date