TakeCare
A TanHoldings Company

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 subscriber address below

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

PLEASE NOTE: *All member checks are made payable to the Subscriber of the plan. *Member checks are valid for 180 days *All request for replacement checks will be subject to a $25 replacement check fee.

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

SUBSCRIBER INFORMATION

Last Name: | First Name: | MI:

ID: | DOB:

Mailing Address

City/Village | State | Zip Code

UPDATED INSURANCE INFORMATION

Primary ID#: | Secondary ID#:

Primary Carrier:
☐ NetCare ☐ SelectCare ☐ StayWell
☐ TakeCare ☐ MediCare
☐ Other

Secondary Carrier:
☐ NetCare ☐ SelectCare ☐ StayWell
☐ TakeCare ☐ MediCare
☐ Other

Subscriber Name: | Subscriber Name:

Subscriber DOB: | Relationship: | Subscriber DOB: | Relationship:

Member Initials

Page 2 must be completed.

TakeCare Representative Initials

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REQUIREMENTS (when applicable)

Outpatient Medical	Inpatient Medical	Pharmacy (Outside the US)	Dental	PI Travel
Pertinent medical records	Itemized billed charges	Prescription slip	Treatment plan (Orthodontic Claims Only)	Airline itinerary
Official proof of payment	Pertinent medical records	Explanations of benefits (Secondary Claims Only)	Pertinent dental records	Official Lodging info
Explanations of benefits (Secondary Claims Only)	Official proof of payment	Official proof of payment	Explanations of benefits (Secondary Claims Only)	Lodging dates
HCFA Claim Form	Explanations of benefits (Secondary Claims Only)		ADA Dental Claim Form	Official proof of payment
	UB04 Claim Form		Official proof of payment	Notice of Benefit Eligibility

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