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An Independent Licensee of the Blue Cross and Blue Shield Association

Member Claim Form – Submission Instructions

Read these submission instructions carefully and submit your completed form with all attachments. Failure to fill out the required fields will result in denial/rejection.

When to Use the Member Claim Form

Use this form only if:

- You received care from a doctor, specialist, or other provider who does not participate with HMSA, and the provider is not submitting the claim on your behalf.
- You received care while away from home and paid for services upfront.
- You are requesting reimbursement for eligible medical services and have all required documentation (itemized receipts with CPT/Dx codes, provider details, etc.).

Do NOT use this form if:

- The provider is in-network with HMSA or another local Blue Cross Blue Shield plan.
- The provider is already submitting the claim for you.
- Your claim is for prescription drugs purchased at a pharmacy (use the Prescription Reimbursement/Drug Claim Form instead).

We offer several convenient ways to submit your claim:

- Online with HMSA's My Account (preferred method)
  1. Log in to our secure member portal online at hmsa.com/my-account to access your secure health plan information.
  2. Click Forms from the drop-down arrow.
  3. Click Medical Receipts and select the appropriate button then click Continue.
  4. Upload your invoices, complete the online form, and click Submit.
- Mail
  - HMSA
    P.O. Box 860
    Honolulu, HI 96808-0860
- In-person at our conveniently located HMSA Centers
  - For help with travel claims, visit us at HMSA Centers in Hilo, Honolulu, Kahului, Lihue, and Pearl City.
  - For current hours of operation, please visit hmsa.com/contact.

Important information

- For most plans, reimbursement requests must be received within a year from the last day on which services were received. For HMSA's Plan for Federal Employees and Postal Service Employees, reimbursement requests will be accepted until Dec. 31 of the year after the year services were received. For more details, see the federal plan brochure or the postal service plan brochure.
- Submit a separate claim form for each member of the family who received services.
- Submit a separate claim form for each provider you saw.
- If your claim is for prescription drugs purchased at a pharmacy, you must submit your claim on a Prescription Reimbursement/Drug Claim Form directly to your plan's pharmacy benefits manager. If your drug plan is with HMSA, your pharmacy benefits manager is CVS and you can get the drug claim form from CVS. You can also get the drug claim form through HMSA's My Account (learn how at https://www.hmsa.com/help-center/how-to-get-copies-of-the-drug-claim-form).
- Attached receipts must include procedure codes (CPT/HCPCS) and diagnosis codes (ICD-10), individual cost per service, provider name, provider address, and applicable provider identifiers such as National Provider Identifier (NPI), Provider Tax ID, and/or State License Number.
- If your address has recently changed, please contact Customer Service using the phone number located on the back of your HMSA card to ensure our records are accurate.
- Keep a copy of this form and your receipts. All submitted documents will not be returned to you.

If you have another primary insurance plan, such as Medicare, and you are submitting your claim to HMSA for any remaining balances after your primary insurance, you must submit a copy of the primary carrier's explanation of benefits or a denial/opt-out letter.

In most cases, HMSA issues member-payable claim payments to the subscriber's address on file. There may be times when payment may be directed to the provider depending on plan type and services received.

Travel reimbursement may be considered taxable income, so you should consult your tax advisor.

Tracking progress

To view the status of your claims, log in to our secure My Account at hmsa.com/my-account. Processing times may vary based on claim complexity and required documentation.

Need help?

Please call us at the number on the back of your HMSA membership card or go to hmsa.com/contact.

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MEMBER CLAIM FORM

Patient's name: (Last name, First name)	Patient's date of birth: (Month/Day/Year) / /	HMSA subscriber ID: (From HMSA membership card)
Patient's phone: (Including area code) ( )	Patient's gender: ☐ Female ☐ Male ☐ Other/Non-Binary	Patient's address (as listed on file): (Street, City, State, ZIP)
Subscriber's name: (Last name, First name)	Patient's relationship to subscriber: (Self, Child, Spouse, Other)	
Subscriber's date of birth: (Month/Day/Year) / /	Group #:	Is this an employer-based health plan: ☐ Yes ☐ No

OTHER INSURANCE INFORMATION

Is the patient covered by another health insurance plan (Including Medicare): ☐ Yes ☐ No	Name of other policy holder: (Last name, First name)	Policy or identification number:
Policy effective date: (Month/Day/Year) / /	Type of policy/Coverage: ☐ Individual ☐ Two-person ☐ Family	Policy holder's date of birth: (Month/Day/Year) / /
Name and address of other insurance carrier:		

PROVIDER INFORMATION FIELDS

Provider and practice/Facility name:*	Provider's phone: (Including area code)* ( )	Provider's address:* (Street, City, State, ZIP)
Ordering or referring provider and state located: (Name, State)	National Provider Identifier (NPI), Provider Tax ID, and/or State License Number)*	

ADDITIONAL INFORMATION

Was the condition related to the patient's employment: ☐ Yes ☐ No	If yes, include date of injury: (Month/Day/Year) / /
Was the condition related to an accident or injury involving another party: ☐ Yes ☐ No	If yes, include date of accident or injury: (Month/Day/Year) / /

CLAIM INFORMATION Please work with your provider to fill in the shaded areas.*

Date of service:* (Month/Day/Year)	**Description of service:***	**Procedure Code (CPT/ HCPCS):*** What was done (e.g., blood test, X-ray).	**Modifier*** Any special circumstances (e.g., test done on both arms).	**Diagnosis Code*** (ICD-10): Why patient was seen (e.g., diabetes, hypertension).	**Charge* $:**	**Units*** Enter number of times procedure was performed.	**Place of Service Code (POS)*** Indicates where service was provided (e.g., office, hospital, telehealth).	**Total Bill:* ($)**

I authorize any hospital, physician, or other provider to release to Hawai'i Medical Service Association (HMSA) any information deemed necessary to process my claim for benefits. The person signing this form understands that the willful making of a false or fraudulent statement herein renders them liable to prosecution.

Signature of Member or Subscriber: _____ Date: _____

*Required