KANSAS FARM BUREAU® Health Plans
Insured By Members Health Insurance Company

Kansas Farm Bureau Health Plans
Post Office Box 1424
Columbia, TN 38402-1424
833-282-5560
www.kfbhealthplans.com

MEDICARE SUPPLEMENT SUBSCRIBER HEALTH CARE CLAIM FORM

-CONFIDENTIAL-

Complete a separate claim form for each patient. Please print.

Patient Information- Complete for all claims.

Patient Name: Subscriber Identification Number:

_____ _____ _____ _____
Last *First* *MI* *(from your ID card)*

Patient Date of Birth: _____/_____/_____
MM *DD* *YYYY*

Address:

_____
Street

_____ _____ _____
City *State* *Zip Code*

Telephone No: ( ) _____

Authorization –Complete for all claims.

Pay benefits for this claim: ☐ **To me, the subscriber**
☐ **Directly to the provider of service (doctor, hospital, clinic, etc.)**

1. I hereby authorize any doctor, hospital, clinic, provider of health care, insurance or reinsurance company, or any other person or firm to release any information requested with respect to this claim and any attached bills.
2. I declare that the information on this claim form and any attached bills is true, complete and correct.
3. I understand it is a crime to knowingly provide false, incomplete or misleading information to Kansas Farm Bureau Health Plans for the purpose of defrauding the company. Penalties may include imprisonment, fines and denial of insurance benefits.

_____ _____
Signature ***Date***

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Instructions for Filing Claims to Kansas Farm Bureau Health Plans

Members: Use the following procedure when your provider does not file a claim. This information applies to any doctor, hospital, clinic or provider of health care.

1. Ask the provider for a claim form you can use to file yourself. All physicians are required to file with Medicare for the patient, even if they do not accept assignment.
2. If the provider cannot give you a claim form you may submit this claim form by following the directions below.
   a. Fill out all the information on the front page of this form.
      - Note the authorization instructions for payment and indicate if the claim should be paid to you directly or to the provider of the service.
      - Sign and date the form.
   b. Attach to the claim form all itemized bills related to this claim. The physician or facility where the service was rendered should provide you with such bills. The itemized bills should include:
      - the name and address of the physician or other provider of service;
      - the name of the patient;
      - the date of each service;
      - the procedure code for each service (your provider can supply these codes) and
      - the amount of charge for each service (cancelled checks, cash register receipts, money orders, credit card vouchers, personal list of services or bills only stating "balance forward" are not acceptable substitutes for itemized bills).

Note: Please keep for your records copies of all information sent to Kansas Farm Bureau Health Plans.

3. Mail the completed claim form and attachments to:

   Kansas Farm Bureau Health Plans
   P.O. Box 1424
   Columbia, TN 38402-1424

4. After your claim is processed, Kansas Farm Bureau Health Plans will send you an Explanation of Benefits (EOB) and a check if you are due payment.

We are truly grateful for the opportunity to be of service to you.