# Geisinger GOLD

**PLEASE READ THE REVERSE SIDE BEFORE COMPLETING THIS FORM**
**YOUR EYEGLASS/HEARING AID CLAIM(S) CANNOT BE PROCESSED UNLESS THIS FORM IS COMPLETE**

MEMBER INFORMATION:

PLEASE PRINT LEGIBLY

| | | | | |
|---|---|---|---|---|
| Member ID Number: | | | Date of Birth: | |
| **Name:** | First | Last | MI | |
| **Address:** | Street | City | State | Zip |

Check if new address: ☐

**A SEPARATE CLAIM FORM MUST BE COMPLETED FOR EACH MEMBER**

HAVE YOU REQUESTED REIMBURSEMENT FOR THIS CLAIM(S) FROM ANYONE OTHER THAN GHP?

☐ YES ☐ NO

**TO BE SUPPLIED BY THE HEALTHCARE PROVIDER:**

**EYEGLASS/HEARING AID INFORMATION:** This section must be completed by your provider. Receipts should be attached.

| | | |
|---|---|---|
| Healthcare Providers Name: | | NPI: |
| Address: | | Phone: |
| City: | State: | Zip code: |

Setting where treatment was received (Sears, Walmart, etc):

| | |
|---|---|
| Diagnosis Codes: | |
| Diagnosis Description: ***(i.e. sensorineural hearing loss, presbyopia)*** | |
| Procedure Codes: ***(for each service provided)*** | |
| Procedure Description(s): **(i.e. single vision lenses, bifocal lenses, monaural in the ear)** | |
| Date(s) of Service: | |
| Amount Paid: | |

| | |
|---|---|
| **PLEASE SIGN AND DATE HERE:** | I certify that all information listed above is correct for myself or members of my family who are eligible. I have received the services above and authorize release of all information contained on this claims to my plan sponsor. |
| MEMBER SIGNATURE DATE | |

PLEASE READ THE FOLLOWING INSTRUTIONS CAREFULLY AND FILL OUT THE FRONT SIDE OF THIS FORM

# A SEPARATE FORM MUST BE COMPLETED FOR EACH MEMBER

## MEMBER SUPPLIED INFORMATION:

1. Please print the requested information
2. Print member's id number (found on your insurance card)
3. Print member's date of birth in the mm/dd/yyyy format
4. Print member's name, first, last, middle initial or as it appears on your insurance card
5. Print member's full address including city, state, and zip code
6. Check the box if this is a new address
7. Indicate if you are seeking other reimbursement for the claims you are submitting

## HEALTHCARE PROVIDER INFORMATION:

1. Print the healthcare provider's name (store number if applicable)
2. Enter the healthcare provider's NPI number
3. Print the healthcare provider's full address including city, state, and zip code
4. Print the healthcare provider's phone #
5. Print the setting where the treatment was received (Sears, Walmart, etc)
6. Enter the diagnosis code
7. Enter the diagnosis description
8. Enter the procedure code
9. Enter the procedure description
10. Enter the date of service in the mm/dd/yyyy format
11. Enter the full amount paid

## IMPORTANT:

1. The member must sign and date each form to be eligible for reimbursement
2. Completion and submission of this form does not guarantee requested reimbursement

**QUESTIONS?** Call Geisinger GOLD Member Services at 1-800-498-9731

**PLEASE RETURN THIS CLAIM FORM TO:**

GHP CLAIMS DEPARTMENT
P O BOX 8200
DANVILLE, PA 17822-8200

# DID YOU SIGN AND DATE THE FRONT OF THIS CLAIM FORM?

Any person knowingly and with intent to defraud any insurance company or other person files an application for insurance or state of claim containing materially false information or conceals for the purpose of misleading, information concerning any material fact thereto commits a fraudulent insurance act, which is a crime and is subject to criminal and civil penalties.