Uprise Health
HMC HealthWorks
SELF-PAY CLAIM FORM

INSTRUCTIONS FOR SUBMITTING CLAIMS

1. Use a separate form for each family member, each different provider of service, and each itemized bill.
2. Attach a fully itemized ORIGINAL bill. Keep a copy for your records.
   FULLY ITEMIZED BILLS MUST CONTAIN THE FOLLOWING INFORMATION:
   date(s) of service, diagnosis(es), type(s) of service, procedure code(s), charge for each service, provider name and type of license, address, phone number, provider tax ID number and provider NPI number (both are necessary).
3. Please send claim to Uprise Health: FAX: 714-556-5430(preferred), Secure EMAIL: hmcclaims@uprisehealth.com or MAIL: 2 Park Plaza, Suite 1200, Irvine, CA 92614

MEMBER INFORMATION (The Policy Holder)

Member's Name on ID card: (Last, First, Middle Initial)			Member's Date of Birth MM / DD / YYYY
Member's Street Address: (Check box if new address ☐)	City	State	Zip Code
Member's ID:	Member's SSN:	Member's Phone #:	Member's Insurance Group:

PATIENT INFORMATION

Patient's Legal Name: (Last, First, Middle Initial)	Patient's Date of Birth MM / DD / YYYY
Patient's Relationship to Member: ☐Self ☐Spouse ☐Child ☐Other: _____	Patient's Sex: ☐Male ☐Female

OTHER COVERAGE INFORMATION (If yes, include a copy of your ID card from Medicare or other Insurance Company)

Does patient have Medicare? ☐Yes ☐No	Part A (Hospital) ☐Yes ☐No	Part B (Physician) ☐Yes ☐No	Effective Date of other coverage MM / DD / YYYY
Is the patient covered under any other insurance policy providing health care benefits or services? ☐Yes ☐No If yes, there is other insurance that is NOT Medicare, please complete a. through c. below:			

a. Name on Other Policy:

b. Name of Insurance:

c. Policy Number:

PATIENT MEDICAL INFORMATION (May be found on itemized Bill or Receipt)

	Date of Service / Visit (MM / DD / YYYY)	Diagnosis Code	Procedure Code(s)	Service Provider Information		
1.				Name:		
2.				Address:		
3.				City:	State:	Zip Code:
4.				**Tax ID #: (Required)**	**NPI #: (Required)**	License Type:

AUTHORIZATION AND SIGNATURE REQUIRED

I certify the above is complete and correct and that I am claiming benefits only for charges incurred by the patient named above. Authorization is hereby given to any hospital, physician, or other provider which participated in any way in my care and treatment to release to Uprise Health any medical information which they in their judgment deem necessary to the adjudication of this claim.

Signature of Policy Holder:	Date MM / DD / YYYY
X_____	

Updated 2023