CHAPTER 7

This Chapter Covers

When to File Claims

Submit within 90 Days

All participating and most nonparticipating providers in Hawaii file claims for you. If your nonparticipating provider does not file for you, please submit an itemized bill or receipt. The bill or receipt must be submitted within 90 days of the last day on which you received services. It must list the services you received. No payment will be made on any claim received by us more than one year after the last day on which you received services. If you have any questions after reading this section, please contact your personnel department, or call us. Our telephone numbers appear on the back cover of this guide.

How to File Claims

One Claim Per Person and Per Provider

File a separate claim for each covered family member and each provider.

You should follow the same procedure for filing a claim for services received in- or out-of-state or out-of-country.

What Information You Must File

Subscriber Number

The subscriber number which appears on your member card.

Provider Statement

The provider statement must be from your provider. All services must be itemized. (Statements you prepare, cash register receipts, receipt of payment notices or balance due notices cannot be accepted.) Without the provider statement, claims are not eligible for benefits. It is helpful to us if the provider statement is in English on the stationery of the provider who performed the service. An accompanying English translation is acceptable.

The provider statement must include:

- Provider's full name and address.
- Patient's name.
- Date(s) you received service(s).
- Date of the injury or start of illness.
- The charge for each service in U.S. currency.
- Description of each service.
- Diagnosis or type of illness or injury.
- Where you received the service (office, outpatient, hospital, etc.).
- If applicable, information about other health coverage you may have.

Telephone Number Please include a phone number where you can be reached during the day.

Signature Make sure you sign the claim.

Other Claim Filing Information

Where to Send Claim Send your claim to the address listed on the back cover of this guide.

Keep a Copy You should keep a copy of the information for your records.

Information given to us will not be returned to you.

Report to Member Once we receive and process your claim, we will send you a report explaining your benefits not later than 30 days after we receive a claim you submit. The ***Report To Member*** tells you how we processed the claim. It includes services performed, the actual charge, any adjustments to the actual charge, our eligible charge, the amount we paid, and the amount you owe.

If we require more information to make a decision about your claim or are unable to make a decision due to circumstances beyond our control, we will extend the time for an additional 15 days. We will let you know within the initial 30-day period why we are extending the time and when you can expect our decision. If we require more information, you will have at least 45 days to provide us the information.

If any of your claims are denied, our report will explain the denial.

If, for any reason, you believe we wrongly denied a claim or coverage request, please call us for help. Our phone numbers appear on the back cover of this guide. If you are not satisfied with the information you receive, and you wish to pursue a claim for coverage, you may request an appeal. See *Chapter 8: Dispute Resolution.*

Cash or Deposit any Benefit Payment in a Timely Manner If a check is enclosed with your Report To Member, you must cash or deposit the check before the check's expiration date. If you ask us to reissue the expired check, there will be a service charge.