Humana Health Plans of Puerto Rico, Inc.
☐ HMO ☐ POS ☐ Other

Humana Insurance of Puerto Rico, Inc.
☐ PPO

Humana®
383 FD Roosevelt Ave.
San Juan PR 00918-2131
Humana.com

REIMBURSEMENT CLAIM FORM

1. Contract or MPI Number: _____
2. Group Number: _____
3. Patient's Name: _____ subscriber ☐ spouse ☐ dependent ☐
4. Postal Address: If you wish to notify change of address other than the one in our records please add here:

   _____

   _____
5. Home Phone No.: __ __ __ - __ __ __ - __ __ __ __
6. Work Phone No.: __ __ __ - __ __ __ - __ __ __ __ Ext. _____
7. Name of provider of services: _____
   (If the Physician is part of a Group, include the name of the Physician)
8. Provider's specialty: _____ Phone No. : __ __ __ - __ __ __ - __ __ __ __
9. Date of service: (Month) __ __ (Day) __ __ (Year)__ __ __ __
10. Condition or diagnosis: _____ CPT Code: _____
11. Any other health plan? ☐ No ☐ Yes – Company: _____ Policy / Contract No.: _____
12. Is this service related to an accident? ☐ No ☐ Yes – Please answer the questions:
    Where? _____ When? _____ How? _____
13.

Services Provided	Charges	Services Provided	Charges
☐ Office Visit &/or Consultation	_____	☐ Laboratory	_____
☐ Radiology	_____	☐ Surgery	_____
☐ Anesthesia	_____	☐ Pharmacy	_____
☐ Procedures	_____	☐ Durable Medical Equip.	_____
☐ Hospital Services	_____	☐ Mental Health	_____
☐ Emergency Room Services	_____	☐ Other	_____

14. Did you contact Humana before service was rendered? ☐ No ☐ Yes, with whom? _____
15. Please explain why you had to pay for the services:

    _____

    _____
16. I CERTIFY THAT THE ABOVE INFORMATION IS CORRECT.

_____ _____ _____
Name Signature Date

INSTRUCTIONS
REIMBURSEMENT CLAIM FORM

The reimbursement claim form must be submitted for all reimbursements.

Must be sure that the information included is correct. (Example: Contract number, date of service, etc.)

The following are the requirements to receive the reimbursement:

1. Original receipt from provider.
2. Name and telephone number of the provider.
3. The form must be completed.
4. Must request the provider to include procedure code and diagnosis, using the corresponding code (ICD -9, CPT-4) and description.
5. Medical order for the services that requires it (purchase or lease of durable medical equipment, diagnostic tests, etc.) The reimbursements for the purchase or lease of durable medical equipment require pre-authorization from Humana.
6. Copy of the referral from PCP, when applicable (only for HMO).
7. In case of Coordination of Benefits, please include the Explanation of Benefits of the Primary Plan
8. Copy of the Rx prescription covered under medical coverage.

If you have other medical plan and your claim is for deductibles or copayments, you must submit copy of the charges paid by the other plan.

Please keep copy of the documents included in this claim.

ANTI-FRAUD LAW

The Articule 27.250 of the Insurance Code of Puerto Rico, 26 L.P.R.A. sec. 2725, of August 9, 2008) mentioned that Any person who, knowingly and with the intend to defraud, presents false information in an insurance request form, or who presents a fraudulent claim for the payment of a loss, will incur a felony, and upon a conviction will be penalized for each violation with a fine no less than five thousand (5,000) dollars nor more than ten thousand (10,000) dollars, or imprisonment for a fixed term of three (3) years, or both penalties. If aggravated circumstances prevail, the fixed establishment imprisonment may be increase to a maximum of five (5) years; if attenuating circumstances prevail, it may be reduced to a minimum of two (2) years.

The non-compliance of the dispositions of this Article will include the imposition of an administrative fine no less than one thousand (1,000) dollars nor more than five thousand (5,000) dollars.

If this notice is not included in the indicated formularies it will not constitute a defense for the insured or third claimant to comply with the dispositions of this Chapter. The breach of the regulations of this Article will entail the imposition of an administrative fine as required by the Article 27.260 of the Insurance Code of Puerto Rico.

Must be submitted on or before one (1) year after services rendered to the following address:

HUMANA
CLAIMS DEPARTMENT
P O BOX 192059
SAN JUAN, PR 00919-2059

For questions or further information, please call our Customer Service Department at:

(787) 282-7900
or our toll free number
1-800-314-3121