



**IBM PPO, IBM PPO Plus, IBM PPO/HSA Options  
 IBM Exclusive Provider Organization  
 IBM Low, Medium and High Deductible PPO Options  
 IBM Medicare Supplement POS**

This form is used to submit claims for any of the benefits listed below. Sections A–E are to be completed by the employee, retiree, eligible surviving spouse/domestic partner as instructed under the individual plan headings. See other side for submission instructions. The word "employee" should be understood throughout this form as including not only employees but also retirees and eligible surviving spouses/domestic partners.

**Note:**

- A different claim form must be completed and submitted to the prescription drug administrator and the Mental Health/Substance Abuse administrator.
- A separate claim form must be submitted for each individual for whom charges are being submitted.
- Please print clearly using blue or black ink.

Complete sections A, B, C, D, and E

For claim inquiries call:

Send completed form to:

**1-800-765-3773**

**MVP Select Care, Inc.**

**TTY: 1-800-662-1220**

**PO Box 1434**

**Group Number: 214459**

**Schenectady, NY 12301-1434**

**A. General Information**

Employee's Name (Last, First, Middle Initial)		
Member Identification Number	Employee's Date of Birth	Employee's Telephone Number

**B. Patient Information**

Self  Spouse  Child  Domestic Partner

Spouse's, Child's or Domestic Partner's First Name (and Last if different from employee's)	Date of Birth	Total Charges
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**C. Other Medical Coverage**

If submitted charges are eligible for coverage/payment from any other source, including other liability claims, check the other source at right. Attach a copy of the other plan's/source's explanation of benefits.

Charges eligible for coverage/payment from:

- Another Employer
- Workers' Compensation
- Automobile Insurance
- Other Private Insurance
- Government Agency
- Medicare
- Other Liability Claims (e.g., awards, judgments, or settlements in connection with auto accidents and tort, malpractice, and product liability claims, etc.)

**Information on Person Carrying Other Insurance**

Name of Person Carrying Other Insurance (Last, First, Middle Initial)

Social Security Number	Date of Birth
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Name of Other Carrier	Policy Number	Employer Name
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**D. Is Treatment Result of Auto Accident? \_\_\_Yes \_\_\_No Other Accident? \_\_\_Yes \_\_\_No**

Complete only if treatment was required because of accidental injury:

Date of Accident: \_\_\_\_\_ Location of Accident: \_\_\_\_\_  
 Description of Accident: \_\_\_\_\_

**E. Benefit Assignment**

(Payment will be made to the provider if you check the box indicating assignment or if no box is checked and the provider's bill indicates that the benefit is assigned.)

- I authorize payment of benefits to all providers.
- I wish benefits to be paid directly to me.

**Payment for services received from a participating network provider will automatically be assigned to the provider. Payment for services received from a non-participating provider will be assigned to the IBM employee/retiree.**

**I certify that the information above and submitted with this claim form is accurate.**

I authorize release of any information relating to this claim to IBM, its contract administrators, or their representatives, as necessary to determine the validity or amount payable on account of this claim. I agree that IBM's contract administrators may release to IBM, or any contract administrator designated by IBM, upon IBM's request, any records and information in its possession in connection with this claim. A photostatic copy of this authorization shall be as effective as the original.

I understand that if I file or authorize another to file a claim knowing that:

1. a provider has waived part or all of a fee or other charge listed in the claim; or
2. the claim contains false, deceptive or misleading information or a deceptive or misleading omission, then I may be subject to dismissal, loss of eligibility under the plans and/or criminal prosecution.

**Reimbursement for Overpayment:** I hereby agree to notify IBM promptly if I become aware of any overpayment of this claim; and to reimburse IBM for any amount paid to me by which a claim payment is finally determined to have exceeded the applicable benefit.

Only an employee, retiree, eligible surviving spouse/domestic partner is authorized to sign this claim form.	Signature	Date
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(12-04)

**See page 2 for submission instructions Page 1**

## How to Submit a Claim

Complete the sections A–E on the front of this form. Send completed form and supporting itemized bills to address as shown on the front of this form.

Claims will only be paid for dependents who are enrolled in the plans listed on the front of this claim form at the time the expense is incurred.

Be sure this form is completed in full, signed, and dated. Incomplete or improperly completed claim submissions will be returned for correction and resubmission.

Claims must be received no later than December 31 of the year after the charges are incurred.

Only one person's charges may be submitted with each claim form. However, more than one bill may be attached for that person.

Submit claims after you have incurred eligible expenses that exceed your annual deductible. By submitting an accumulated bill, you help to reduce IBM's administrative costs.

Keep a copy of the claim form and supporting bills for your records. This will help you reconcile them to the Explanation of Benefits (EOB) you will receive. Duplicate copies of claim data or EOB statements will not be provided.

All bills must be itemized and must clearly indicate the following:

- Date of service
- Procedure and diagnosis codes
- Name and address of provider rendering the service
- The nature of illness or injury and/or ICD-9 diagnosis code
- The Tax ID# of the provider

Cancelled checks and cash register receipts are not acceptable. All bills must show the name and address of the provider of services.

Include English translation of diagnosis and treatment for services rendered outside of the United States.

If bills are being submitted for nursing services, physical therapy or medical supplies, enclose a statement from your physician detailing why services and supplies are medically necessary.

Participating network providers (e.g., hospitals, doctors, labs, etc.) must send claims to MVP Select Care, Inc. at the address on the front of this form.

If IBM provides secondary coverage (e.g., Medicare is primary), claims should be submitted to the address on the front of this form after the primary coverage has considered the claim.

All claim inquiries should be directed to the plan administrator's 800 number (see front of claim form). Please allow at least 21 days after mailing of your claim before calling.

Enrollment questions should be directed to the IBM Employee Services Center at 1-800-796-9876 (TTY: 1-800-426-6537)