PRESCRIPTION (School District Plan B only) / DENTALAND MEDICAL (MEMBER PAID) CLAIM FORM

Fairbanks North Star Borough & Fairbanks North Star Borough School District

Plan P62

(A Self-Funded Health Plan)

Instructions:
Please complete this form, attach all itemized bills, and keep a copy for your records. You may return this form to WPAS, Inc. in one of the following ways:

1. **Mail to:**
   WPAS, Inc.
   PO Box 34840
   Seattle, WA 98124-1840
2. **Fax to:**
   (206) 441-9110
3. **Email scanned documents to:**
   claimsubmissions@wpas-inc.com

Part I - Type(s) of Claim: Check type(s) ☐ Medical (member paid) ☐ Prescription (Plan B) ☐ Dental (member paid) ☐ Audio (Hearing) (Prescriptions for Borough and School District Plan A or C Employees must be filed through CVS Caremark) (All Vision must filed through VSP)

Part II - Employee Data:
Employee Name: _____ Employee ID or Social Security Number: _____
(First Name) (Last Name)
Reminder: Please contact your Personnel Department for all address changes.

Part III - Patient Data:
Patient Name: _____ Birth Date: ___/___/___ Claim is for: ☐Employee ☐Spouse ☐Dependent Child
(First Name) (Last Name)
If claim is for dependent child, indicate relationship:
☐ Child ☐ Step Child ☐ Legal Guardianship ☐ Other _____
If child is age 26 or older, does child have a developmental disability or physical handicap that began before attaining age 19? ☐Yes ☐No

Part IV - Other Insurance Information:
Does patient, participant's spouse or the patient's spouse have other health insurance coverage? ☐No ☐Yes If yes, please complete the following for each policy/plan:
Insurance company/plan administrator's name, address, telephone #, policy/plan #, and types of coverage:
1. _____ ☐Medical ☐Dental ☐Vision
2. _____ ☐Medical ☐Dental ☐Vision
Is spouse employed? ☐No ☐Yes If yes, please write name, address and telephone number of employer and/or union local:
_____

Part V - Claim Information (complete only applicable information):
Medical - Are expenses related to an accident? ☐No ☐Yes If yes, indicate date of accident ___/___/___ and type of accident:
☐ Automobile
☐ Employment-Related: Name, address & telephone of employer: _____
☐ Home/Recreational ☐ Other _____
Briefly describe accident: _____
_____
Note: If expenses are related to an accident, you will receive an "accident questionnaire" from WPAS. Please respond promptly to expedite timely claim processing.

Dental - Is this for: ☐Pre-treatment plan and/or ☐Services already rendered

Prescriptions ☐School District Plan B
Borough and School District Plan A or C Employees must file with CVS Caremark

Part VI - Authorization To Process Claim:
In order to process a claim for benefits, I authorize any physician, hospital or other health care provider to release to Welfare & Pension Administration Service, Inc. and the planholder, or their representatives, any information regarding my and/or minor dependent's health history, symptoms, treatment , examination results or diagnosis. This authorization shall be considered valid for the duration of the claim. ***Any person who knowingly and with intent to defraud or deceive any health plan, files a statement of claim containing any materially false, incomplete or misleading information is guilty of a crime and may be liable for substantial civil penalties.***

I AUTHORIZE BENEFIT PAYMENT TO THE HEALTH PROVIDER FOR THE SERVICES AND/OR SUPPLIES DESCRIBED ON THIS CLAIM FORM. ☐Yes ☐No

_____ _____/_____/_____
Eligible Participant's Signature Date

CLAIM FILING TIPS

We want your claims to be paid accurately and timely. Using the following tips will help us give you better service.

DO'S

- Answer all the appropriate questions and sign the claim form.
- Always send your claim form and an itemized statement of charges which include:

1. Employee name
2. Patient name
3. Provider name, address & Tax ID number
4. Dates of service
5. Diagnosis (preferably with code number)
6. Types of service (preferably with code number)
7. Charges for each type of service

- If you have other insurance coverage, please remember to submit the claim to the primary insurance plan first. (Refer to your health plan benefit booklet, "coordination of benefits" section to determine which plan is primary). When you receive the "Explanation of Benefits (EOB)" statement back from the primary plan, submit the claim to the secondary plan by sending that plan's claim form, a copy of the bill and a copy of the primary plan's EOB.

  Exception: WPAS will internally coordinate the processing of a claim, if both Plans are administered by WPAS.

- Please ensure your provider pre-certifies "in-patient hospital confinement and certain services" by having the provider call Aetna at 1-888-632-3862.
- Have your dentist submit a "pre-treatment dental plan" for all claims expected to exceed $400 to WPAS. This will let you know your "out-of-pocket expenses" before services are rendered.

DONT'S

- Never send a "balance forward bill" to WPAS.
- Make certain you know who is going to file your claim. Do not submit a claim yourself if your health care provider tells you they will submit the claim for you. Duplicate claim filing adds to the administrative expense of operating our plan. Aetna preferred providers will file your claim for you.
- If you believe your claim was paid incorrectly, call WPAS first at 1-800-331-6158, Option 8. If you are not satisfied with the response, call Risk Management at (907) 459-1344. Always write down who you spoke with at WPAS, date & time.

For Toll-Free Assistance Nationwide Call:
Welfare & Pension Administration Service, Inc
Claims Office 1-800-331-6158, Press Option 8