TELEHEALTH CLAIM FORM

Patient Reimbursement Request

Fax or mail to your insurance provider

For additional information, please contact your health plan administrator

Health Plan: PLEASE REMIT PAYMENT DIRECTLY TO THE PATIENT WHO HAS ALREADY PAID PROVIDER.

SECTION 1: PATIENT INFORMATION

Patient Name (Last, First, Middle Initial)

Patient Date of Birth

Patient Address

SECTION 2: INSURANCE INFORMATION

Insured's Name (Last, First, Middle Initial)

Insured's Member ID

Insured's Date of Birth

Relationship to Patient

☐ Self ☐ Spouse ☐ Parent ☐ Other

SECTION 3: YOUR HEALTHCARE EXPENSES

Service provided via DermatologistOnCall teledermatology platform

Iagnosis Medical Group	NPI #: 1972048288	EIN (Tax ID): 81-4758343
Provider Name		
Procedure Code	99422-GQ Teledermatology and Asynchronous Services	Place of Service: 02 – Teledermatology
Diagnosis Codes *(see visit receipt)*	ICD-9 Code:	ICD-10 Code:

Total Amount Paid

Supporting documentation attached? **Yes** ☐ **No** ☐

(include visit receipt)

SECTION 4: CERTIFICATION Please read carefully before signing.

I affirm that:

- **I have not been reimbursed for these telehealth services/expenses from my FSA or HSA and I have not requested and will not receive reimbursement for these expenses from any other plan including FEDVIP (Federal Employees Dental and Vision Insurance Program) and FEHB (Federal Employees Health Benefits Program); AND**
- **I have submitted the above information in good faith and it is correct to the best of my knowledge.**

Patient/Guardian Signature* ____

Date (mm/dd/yyyy) ____

Your signature and date are required in order to process your claim for reimbursement.