Member Claim Form

Please complete the claim form and attach required documentation. Complete submission of all fields will help ensure quick and accurate processing. See pages 2-3 for complete instructions. Please note that this form can only be used for Medical Claims. It is not intended for Dental, Vision or Pharmacy claims.

***Note: The healthcare provider normally files the claim for you. You only need to fill out this form if your healthcare provider does not file the claim for you. This should only apply to out of-network providers. Please use a separate claim form for each unique provider.

If the claim is for services rendered to the Primary Subscriber, the following section should be filled out.

Oscar Member Information		
Member First Name	Member Last Name	Member Oscar ID (OSC#xxxxxxxx-xx)
Member Date of Birth (yyyy/mm/dd)	Daytime Telephone # (Optional)	

If the claim is for services rendered to a child or dependent, the following section should be filled out in addition to the section above.

Oscar Patient Information (Complete only if patient is not the Primary Subscriber)		
Patient First Name	Patient Last Name	Patient Oscar ID (OSC# xxxxxxxx-xx)
Patient Date of Birth (yyyy/mm/dd)	Daytime Telephone # (Optional)	Patient Relationship to Primary Member

Oscar Member Other Coverage		
Were you in an accident?	Was it employment related?	Was it an automotive accident?
Do you have any other type of coverage (other commercial carrier, Medicare, or Medicaid)?		

Provider Information	
Provider Name	Provider Address
Provider Specialty (optional)	Provider Telephone # (Optional)
Provider Tax ID (TIN)	National Provider Identification #

Medical Claim Information				
Date of Service (yyyy/mm/dd)	Diagnosis Codes	Procedure Codes	Description of Services (optional)	Charges ($ amount billed)

HEALTHCARE SERVICES: Use this section to report any COVERED health service that has not already been reported by the provider of service (e.g., physician, clinical, ambulance company, private duty nurse). Attach itemized bill(s). Please be sure that duplicate bills are not submitted.
Please use a separate claim form for each provider.

I certify that, to the best of my knowledge, the information on this Member Claim Form is true and correct. I understand that any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files any claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

I authorize the release of any medical information necessary to process this claim.

Signature	Printed Name	Date
X		

Oscar is the brand name used for products and services provided by one or more of the licensed Oscar family of companies including, but not necessarily limited to, Oscar Insurance Corporation, Oscar Insurance Company, Oscar Health Plan of California, Oscar Garden State Insurance Corporation, Oscar Insurance Corporation of Ohio, Oscar Buckeye State Insurance Corporation, Oscar Insurance Company of Florida and Oscar Health Plan, Inc.

Instructions

Usually, all health care providers will bill Oscar for services to you and your enrolled dependents. This is the preferred procedure, so you are not bothered with claim forms and we often need more details than are ordinarily provided on bills to patients. If a provider is unwilling to bill Oscar, they may send the bill directly to you. Use this Member Claim Form to notify us of any covered health service for which we have not already been billed.

NOTE: Incomplete claim forms will be returned to you for missing information. This will delay the processing of the claim. For faster, easier processing of claims, the provider should submit a claim to us directly. Electronic claim submissions are also accepted.

1. We must receive your claim form within a specific period of time from the date you received the service, unless your plan or state laws allow for more time.

- AL, AR, AZ, CA, FL, IL, NE, NJ, NY, NC, OH, OK, TX, IA : 180 days from the date of service
  - Exception:
    - FL (out-of-network claims): 6 months from the date of service
    - NY (out-of-network claims): 120 days from the date of service
    - TX (out-of-network claims): 95 days from the date of service
- MI, MO: 365 days from the date of service
  - Exception:
    - MI (in-network claims): 6 months from the date of service
- CO, GA, KS, PA, VA: 120 days from the date of service

- TN: 90 days from the date of service
- MS: 30 days from the date of service

2. Please use a separate claim form for each health care professional, and for each member of your family. You can get a new blank form by going to www.hioscar.com/forms and clicking on the "Member Claim Form" link, or by calling Customer Service at the toll-free number 855-672-2755.
3. Complete items in full.
4. Be certain to sign the authorization on page 2.
5. Attach itemized bills or ask your healthcare provider to submit the claim directly to us. The bills must include:
    - Name and address of provider (e.g., doctor, hospital, laboratory, ambulance service)
    - Name of patient
    - Service provided
    - Date of service
    - Amount charged for each service
    - Diagnosis code (ICD format)
    - Procedure code(s)
    - Tax ID

    If this information is missing, write it on the bill. Cancelled checks, cash register receipts and non-itemized "balance due" statements cannot be processed.
6. Retain copies of your bills and claim forms for your record.
7. We pay covered claims directly to any health care professional with an Oscar contract. We only send the payment to you when the health care professional has indicated as such on their claim submission. We reserve the right to request other documents, such as medical records, if we need them before processing your claim.
8. Mail all completed materials to the following address based on your plan state. Allow 4-6 weeks for processing. You may also send the form via email to help@hioscar.com, secure message, or fax to (888) 977-2062.

Mail Claim Forms To:

Oscar
P.O. Box 52146
Phoenix, AZ 85072-2146
Electronic Payor ID: OSCAR

Explanation of Benefits (EOB)

Once we've processed the claim, you'll receive an EOB. The EOB will explain the charges applied to your deductible (the amount you pay for covered services before your plan begins to pay) and any charges you owe your health care professional. Please keep your EOB on file in case you need it in the future.

Caution: Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any

materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Attention Arizona Residents: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

Attention California Residents: For your protection California law requires notice of the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Attention Florida Residents: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Attention New Jersey Residents: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

Attention New York Residents: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each violation.

Attention Ohio Residents: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Attention Texas Residents: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Attention Tennessee Residents: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.