WVCHIP Hemophilia Reimbursement

Member's (Child) Name: _____

Last First Middle

Identification Number: _____ Member Date of Birth: _____

Home Address: _____

_____

Phone Number: _____ Member's Sex: ☐ Male ☐ Female

Mileage: _____

Starting Location/Address: _____

Ending Location/Address: _____

Round Trip? ☐ Yes ☐ No

Lodging: _____ (total) Meals: _____ (total – up to $30 per day/person)

I certify that the above is correct and that I am claiming benefits only for charges incurred by the patient named above. I further authorize release of any medical information necessary to process this claim.

Signature of Member's Parent/Guardian/Representative: _____

Date: _____

Itemized bills must accompany this claim form. These bills must include the following information:

1. Name of child covered by WVCHIP
2. The WVCHIP Policyholder's identification number
3. The nature of the illness or injury
4. Date(s) of service
5. A complete description of each service
6. The amount charged for each service
7. Diagnosis and procedure codes for each illness, condition and procedure
8. The provider's name, address and NPI number

Mail to: The Health Plan, 1110 Main Street, Wheeling, WV 26003

If you have questions, please call THP's Customer Service toll-free at: 1.888.613.8385 (TTY:711)