



Qualcomm Doula Claim Form

Effective 1/1/2020

Alert: This cover sheet must be placed on top of each Qualcomm Doula Claim Form before submission.

Member ID: _____

Member Policy: 704201

Mail To: PO Box 30431 Salt Lake City UT, 84130

Fax#: 801-938-2102

Attention RMO:

Sort this mail as Non Keyable

CAR_SCRN

Group Number: 704201

Member ID (from Health Plan ID card, can be up to 11 digits) : _____

Patient Information.

Name (Last, First, MI): _____

Date of Birth: ____ / ____ / _____

Home Address: _____

Gender: M F

City: _____ State _____ Zip: _____

Relationship:
 Subscriber Child
 Spouse/Partner Other Dependent

Phone # (include Area Code): _____

Check if New Address:

Employee Information. (Complete this information only if it is different than the patient information.)

Employee Name (Last, First, MI): _____

Phone #: _____

Home Address: _____

Date of Birth: ____ / ____ / _____

City: _____ State: _____ Zip: _____

Check if New Address:

Provider Information. (This information is required to process the claim.)

Provider Name: _____

Address: _____

Number of pages with invoices/receipts attached: _____ Total Amount Submitted For Reimbursement:
\$ _____

Date(s) of Service: _____

Description of Services provided: _____

License Number (as stated on license or certificate): _____

By signing below, I am stating that the information above is correct. Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information, may be guilty of a criminal act punishable under law and may be subject to civil penalties.

Signature: _____

Date: ____ / ____ / _____

INSTRUCTIONS:

Please mail this form with photocopies of dated proof of payment and/or.

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INTERNAL USE ONLY

FOR PROCESSING USE:

For Doula Services Only: ICD-10: Z34.90, CPT: SPEC2, Place of Service (POS): OL, TIN: 0-006900001

Attention Keying: Please input keyed comments of 'Stop Auto'