

CLAIM HISTORY COVER SHEET

Dear Employee,

So that Neighborhood Health Partnership (NHP) may properly credit deductibles, out-of-pocket amounts, or other maximums that you and each of your covered dependents satisfied while covered under the prior carrier, we need copies of the prior carrier Explanation of Benefit (EOB) statements.

Note: In order to ensure prompt and accurate claim processing, this information is needed as soon as possible.

If the most recent EOB for you and each dependent received from the prior carrier includes the total amount satisfied during the benefit year, we will only need copies of those EOBs. If, however, the EOBs only show the amount satisfied on each claim, we will need copies of all EOBs for the benefit year so that we may have complete information.

After you have gathered the EOBs, please complete the information below and mail it, along with the EOBs, to the following address:

Neighborhood Health Partnership
Attention: Enrollment Department
P.O. Box 025680
Miami, FL 33102

Employer Name: _____

Group Number (if available): _____

Employee Name: _____

Employee Address: _____

Nine Digit NHP Member ID Number: _____

(List names of those that you are providing EOBs for. If yourself, check “Yes” next to “Self” below.):

Self: **Yes** _____ **No** _____

Dependent Name: _____

Dependent Name: _____

Dependent Name: _____

Dependent Name: _____

Dependent Name: _____