



HealthPartners Medical Claim Attachment Cover Form

Attachments to claims submitted electronically to HealthPartners can be submitted by mail, fax or via the web. Use this cover form for attachments submitted by mail or fax.

Mail form and attachment to:
HealthPartners Medical Claims
PO Box 1289
Minneapolis, MN 55440-1289

Fax form and attachment to:
(952) 853-8860
This fax number is only for attachments.

Complete this section for each attachment.

Attachment Control ID: <i>You assign unique ID for each attachment and submit this ID on your electronic claim</i>	<input type="text"/>
Billing Entity TIN: <i>Type II NPI is also acceptable</i>	<input type="text"/>
Clinic	<input type="text"/>
Patient Name:	<input type="text"/>
<i>last</i> <i>first</i> <i>middle</i>	
HealthPartners Member ID:	<input type="text"/>
Date Attachment Sent:	<input type="text"/>
Total # Pages for Attachment: <i>Including this cover form</i>	<input type="text"/>
Clinic Contact: <i>(name and phone #)</i>	<input type="text"/>
Property & Casualty Claim #:	<input type="text"/>

Disclaimer:

For more information on electronic claims submissions, copies of this form, or to upload your attachment directly, visit <http://www.healthpartners.com/provider>.