Nonstop Insurance and Administration Services, Inc. (Nonstop Health)

Dear provider,

Your patient, _____, is enrolled in program called Nonstop Health — a type of HRA (MERP) administered by Nonstop Administration and Insurance Services, Inc. Nonstop Health serves as a secondary payer (not a secondary insurer) for covered medical expenses and prescriptions, meaning members may use the program to pay for in-network* eligible expenses like deductibles and coinsurance.

You are receiving this notice because your patient would like you to bill Nonstop Health directly for any remaining expenses after you process the medical services through the patient's health insurance carrier and receive payment from them.

To direct bill Nonstop:

First: Submit the claim to the patient's health insurance carrier, as you normally do.
Once payment is received by the insurance carrier.
Then: Submit claim to Nonstop with:

- Nonstop's Service Provider Claim form, filled in completely
- Finalized Explanation of Benefits (EOB) from the health insurance carrier

Submit claims to Nonstop in one of the following ways:

EMAIL	FAX	MAIL
claims@nonstophealth.com	877.463.1175	1800 Sutter St. Suite 730 Concord CA 94520

Nonstop Health does NOT cover:

- ✖ Out-of-network* providers or facilities
- ✖ Non-covered services or prescriptions
- ✖ Routine dental**
- ✖ Routine vision**
- ✖ Over-the-counter medication
- ✖ Anything the health insurance carrier does not apply toward the member's in-network* deductible and/or out-of-pocket maximum

Nonstop will process and pay any eligible expenses via check (we do not use electronic feeds) within 30 days.

**If your patient is on a version of Nonstop Health that allows for out-of-network coverage, this does not apply. Not sure? Contact Nonstop.*

*** Unless covered under the patient's medical plans and costs are applied toward the medical plan's in-network* deductible and/or out-of-pocket maximum.*

Questions? We're here to help!
877.626.6057 Mon-Fri 6am-5pm PT/9am-8pm ET
clientsupport@nonstophealth.com

Number of pages including this cover sheet _____

nonstop™

Service Provider Claim Form

Employee/Patient Information:

Last Name	First Name	Middle Initial
Home Address	City / State	Zip Code
Phone	Email	Date of Birth

ITEMS REQUIRED FOR SUBMITTING THIS FORM:

1. Fill out the form completely. All the requested information below is necessary.
2. Sign, date, and return the form to Nonstop Health Claims via fax (877.463.1175), email (claims@nonstophealth.com) or regular mail (1800 Sutter St. Suite 730 Concord CA 94520).
3. Attach an Explanation of Benefits (EOB) and itemized bill or HIFC.
4. EOB must include: Date of service, description of service, amount the patient is responsible for, clearly listed carrier adjustments, and remarks codes explaining each code.

All information MUST be included for the claim to be processed.

Date of Service	Type of Expense	Name of Member or Dependent	Patient's Responsibility
		Total Reimbursement Requested	

Provider's Name	Phone Number
Mailing Address	

SUBMIT TO NONSTOP HEALTH CLAIMS
1800 Sutter St. Suite 730 Concord CA 94520
Phone: 877.626.6057 • Fax: 877.463.1175
Email: claims@nonstophealth.com

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