MetroPlusHealth

MEDICARE MEMBER REQUEST FOR DIRECT REIMBURSEMENT FORM

USE THIS FORM TO ASK FOR REIMBURSEMENT FOR ELIGIBLE CARE AND SERVICES THAT YOU HAVE ALREADY PAID FOR WITH A CREDIT CARD, CASH, OR CHECK.

This form cannot be used for reimbursement requests for non-eligible care or services. To ensure timely processing, please fill out all requested information and attach supporting documentation. Incomplete requests will be returned. Please complete one form for each individual reimbursement request.

IF YOU HAVE ANY QUESTIONS OR NEED HELP FILLING OUT THIS FORM, please contact our Member Services Helpline at: 1.866.986.0356 • TTY: 711, 7 days a week, 8am-8pm. If you need in-person assistance with filling out this form, please visit one of our Community Offices. For office locations, please visit our website at: www.metroplus.org/metroplus-near-you .

INSTRUCTIONS

SECTION 1 – MEMBER INFORMATION:

- ✓ Write your Member ID number, which is found on your member ID card
- ✓ Write your Group Number, which is found on your member ID card
- ✓ Write your Name as shown on your member ID card
- ✓ Write the number you want to be contacted at in case we need to verify any information.

SECTION 2 – REIMBURSEMENT DETAILS:

- ✓ Write in the date of service
- ✓ Check off reason for reimbursement
- ✓ Write all Provider details
- ✓ Write in the total that you paid out of pocket

SECTION 3 – SUPPORTING DOCUMENTATION: (Do not submit any original documents - only submit copies):

- ✓ Please make sure your supporting documentation is clear and readable
- ✓ Please include proof of payment and a copy of the itemized bill from the Provider
  - Please do not send credit card receipts, cashed checks, or copies of checks. They are not acceptable receipts for reimbursement.
  - If you do not have proof of payment, please request a copy from the Provider
  - Reimbursement requests that do not include proof of payment may be dismissed
  - Gym Member Reimbursement: Please submit Proof of payment issued by the Gym
- ✓ Write your Member ID at the top of each page of any supporting documents

SECTION 4 – MEMBER ATTESTATION:

- ✓ Sign and date your form to certify the information on the form and in the documents are accurate and complete.

If you are acting as a Beneficiary Representative, be sure to complete and attach the *Appointment of Representative Form*, available at: **https://www.cms.gov/cms1696-appointment-representative** .

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SECTION 1: MEMBER INFORMATION		
First Name:	Last Name:	Member ID #:
Street Address:		Medicare ID #:
City, State, Zip:		Telephone #: ( )

SECTION 2: REIMBURSEMENT DETAILS

Date of Service (MM/DD/YYYY): _____

☐ I went to an out-of-network Provider (please explain): _____

_____

_____

☐ I did not have my Member ID Card

☐ I am requesting a transportation reimbursement

☐ Gym reimbursement (S9970, Y92.838)

☐ Other (please explain): _____

PROVIDER INFORMATION

Provider's Name:		
Description of Care or Service:		
Date of Care or Service:	Amount Paid:	
Street Address:	City, State:	Zip:

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PROVIDER INFORMATION		
Provider's Name:		
Description of Care or Service:		
Date of Care or Service:	Amount Paid:	
Street Address:	City, State:	Zip:

SECTION 3: SUPPORTING DOCUMENTATION

☐ Receipt of payment from Provider ☐ Paid receipt of services
☐ Itemized receipts or claim form for services ☐ Superbill

SECTION 4: MEMBER ATTESTATION

You understand that if the services are deemed covered services, then the health plan will reimburse you up to the benefit amount minus any applicable deductible, coinsurance, or copayments. You understand that to process the claim we may need to disclose the information on the form to other persons and entities.

By signing below, I attest that I have paid the dollar amount listed below for the services received while a MetroPlus Health **Plan member. I further confirm that the documents attached to this form proving proof of payment are accurate, true, and complete. I understand that my request can be denied if I do not provide required documentation to support my request for reimbursement.**

Sign Here ► _____ **Date:** _____

*If you are the authorized representative, you must sign above and provide the following information:

Name:	Relationship to Enrollee:
Street Address:	
City, State, Zip:	Telephone #: ( )

Please check if you are the: ☐ **Member** **OR** ☐ **Beneficiary Representative**

If you are the Beneficiary Representative, please attach the required Appointment of Representation (AOR), Power of Attorney, or Executor of Estate form. The AOR form can be found at **https://www.cms.gov/cms1696-appointment-representative**

Please submit entire form and all supporting documentation to:

MetroPlusHealth • Att: Claims
160 Water Street, 3rd Floor • New York, NY
10038 Fax: 212.908.5196

MetroPlus Medicare Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age,disability, or sex. ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-866-986- 0356 (TTY: 711). H0423_MEM21_2474_C_0223221