

# TUFTS Health Plan Medicare Preferred

## MEMBER REIMBURSEMENT FORM

<b>1. Member Name:</b>	<b>2. Member ID #:</b>
<b>3. Name of Provider of Service:</b>	<b>4. Telephone Number and Address of Provider (if known):</b>
<b>5. Date(s) of Service:</b>	<b>6. In what setting did you receive treatment?</b> (e.g.: office, ER, hospital, clinic, etc)
<b>Use reverse side or another sheet of paper to include any additional information if necessary.</b>	
<b>7. Are you responsible for any co-payments, coinsurance, or deductibles for this service?</b> No _____ Yes _____ Not Sure _____ Note: Any reimbursement made will be less applicable co-payments, coinsurance, or deductible.	
<b>8. Amount of reimbursement you are requesting. \$</b> _____	
<b>9. If services were performed outside the USA:</b> In what country were services performed? _____ In what language was the bill/receipt written? _____ In what currency was the bill paid? _____	
<b>10. What were you seen for? (e.g.: flu, broken leg, asthma, etc.)</b>	
<b>11. Describe the services that were provided to you. (e.g.: lab work, ER visit, flu shot, etc.)</b>	
<b>12. Please include Proof of Payment AND Itemized Receipt*</b> <b>Circle which of the following acceptable proof of payment you are attaching to this form.</b> <ul style="list-style-type: none"> <li>• A copy of the front and back of the cancelled check written to the provider or the bank encoded front of the check written to the provider.</li> <li>• A credit card statement or receipt with itemized bill and authorization if applicable.</li> <li>• A statement from the provider, on the provider's letterhead with authorized signature, indicating payment was made.</li> </ul>	
*A receipt for purchased items, with the provider's name and address preprinted on the receipt, with items listed and the amount paid.      *Prescription required for Durable Medical Equipment purchase.	
<b>13. Signature is required</b> I attest that the above information is accurate and complete. _____	
<b>INTERNAL USE ONLY</b> Claim # _____ Claims Status _____ Provider #: _____ Post Cataract Eyewear Procedure Codes _____	

NOTE: Do not use this form for Weight Watchers or Fitness reimbursement. For Weight Watchers reimbursement, use the Tufts Medicare Preferred Member Attendance Tracker form. For Fitness use the Fitness Reimbursement form.

**Tufts Health Plan Medicare Preferred  
Customer Relations  
P.O. Box 9181  
Watertown, MA 02471-9181**