MEMBER REIMBURSEMENT FORM

TUFTS Health Plan Medicare Preferred

REQUIRED INFORMATION

Member Name: _____ **Member ID#:** _____

Name of Provider of Service: _____ **Date(s) of Service:** _____

Telephone Number and Address of Provider (if known): _____

In what setting did you receive treatment? (e.g. office, ER, hospital, clinic, Weight Watchers, etc.)

_____

Use reverse side or another sheet of paper to include any additional information if necessary.

Amount of reimbursement you are requesting: $_____

Note: Any reimbursement made will be less applicable co-payments, coinsurance, or deductible.

If services were performed outside of the USA:

In what country were services performed? _____

In what language was the bill/receipt written? _____

In what currency was the bill paid? _____

Describe the items or services that you were seen for.[1]
(e.g. asthma, lab work, ER visit, flu shot, weight loss, durable medical equipment[2], etc.)

_____

Please include Proof of Payment AND Itemized Receipt[3]
Check which of the following acceptable proof of payment you are attaching to this form.

- ❑ 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.
- ❑ A credit card statement or receipt with itemized bill and authorization, if applicable.
- ❑ A statement from the provider, on the provider's letterhead with authorized signature, indicating payment was made.

[1] Tufts Health Plan Medicare Preferred requires prior authorization for certain drugs, devices, and equipment as a condition of payment. Refer to your Evidence of Coverage booklet for your plan's guidelines.
[2] Prescription required for Durable Medical Equipment purchase.
[3] A receipt for purchased items, with the provider's name and address preprinted on the receipt, with items listed and the amount paid.

SIGNATURE IS REQUIRED

I attest that the above information is accurate and complete.

Member's Signature: _____ Date: _____

NOTE: For Wellness reimbursement, please use the Wellness Benefit form. For Eyemed reimbursement from a non-plan provider, please use the Out of Network Vision Services Claim Form.

Tufts Health Plan Medicare Preferred
Member Reimbursement
P.O. Box 9183
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