TUFTS Health Plan

Tufts Health Plan Group Retiree Plan Member Reimbursement Form

This form allows Tufts Health Plan Group Retiree Plan members to request reimbursement for any health care services you have received that were not initially covered by Tufts Health Plan (including out-of-country health care services).

If a Member Reimbursement Form is being submitted by an Authorized Representative, please complete and include the Tufts Health Plan *Appointment of Personal Representative (AOR) Form*, or any legal documentation verifying personal representation, with your request. We require verification of the authority of an Authorized Representative before the request can be processed. You can find the AOR Form on our website at **thpmp.org/tmp-aor-form**.

☐ **I am completing this form as an Authorized Representative to the subscriber.**

Member Information

First name | M.I. | Last name

Date of birth | Member ID number

Service Information (Include any additional information on separate sheet)

Name of service provider

Street address

City | State | ZIP

IF SERVICES WERE PERFORMED OUTSIDE USA

Country of service

Language of bill/receipt | Currency of bill

In what setting did you receive treatment?

◯ Office ◯ ER ◯ Hospital ◯ Clinic ◯ Other

Describe the items/services received
(e.g., asthma treatment, lab work, ER visit, flu shot, eyewear, durable medical equipment,[1] dental services, etc.)

Service date(s)

Procedure code (optional)

Reimbursement Information

Amount of reimbursement you are requesting

$ _____ . ____ ☐ Amount is in another currency (as specified on page 1)

Please include proof of payment and itemized receipt.[2]

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.

Signature

I attest that the information is accurate and complete.

Signature _____ Date _____

Instructions

Please mail this completed form to:

Tufts Health Plan
Attn: Member Reimbursement
P.O. Box 214
Canton, MA 02021-0214

For more information:

Call Member Services at
1-800-936-1902 (TTY: 711)
8 a.m.–8 p.m., 7 days a week
(Mon.–Fri. from Apr. 1–Sept. 30).

[1]Prescription required for durable medical equipment purchase.

[2]A receipt for purchased items, with the provider's name and address preprinted on the receipt, with items listed and the amount paid.