MEMBER REIMBURSEMENT FORM

TUFTS Health Plan Medicare Preferred

REQUIRED INFORMATION

Member Name: _____

Member ID#: _____ **Member Date of Birth:** _____/_____/_____

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, 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 cost-sharing. See your benefits document for details.

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, eyewear, 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 Medicare Preferred HMO 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 may be required for Durable Medical Equipment purchase. See your benefit document for details.
[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 HMO members looking to submit for Wellness Allowance reimbursement, please use the Wellness Allowance Benefit Form. For Medicare Supplement members looking to submit for Fitness and Nutritional Counseling reimbursement, please use the Fitness and Nutritional Counseling Benefit Form. For HMO members looking 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
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