TUFTS Health Plan

SCO Member Reimbursement Form

This form allows Tufts Health Plan Senior Care Options plan members to request reimbursement for any healthcare services you have received that were not initially covered by Tufts Health Plan (including out-of-country healthcare services). Please note that this form is not intended to be used for Wellness Allowance reimbursements, Weight Management reimbursements, Fitness and Nutritional Counseling reimbursements, or for non-plan vision provider reimbursements through Eyemed.

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

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

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Service Information (include any additional information on separate sheet)

Name of service provider

Street address

City State Zip

In what setting did you receive treatment?

Office ER Hospital Clinic Other

Service date(s)

Describe the items/services that were received[1] *(e.g. lab work, ER visit, etc.)*

If services were performed outside USA

Country of service

Language of bill/receipt

Currency of bill

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.

I attest that the information is accurate and complete.

Signature _____ Date _____

Instructions

Please mail this completed form to:

Tufts Health Plan Senior Care Options,
Attn: Member Reimbursement
P.O. Box 9183
Watertown, MA 02471-9183

For more information, call Customer Relations at **855-670-5934** (TTY: 711).

Representatives are available Monday–Friday, 8 a.m.–8 p.m. (October 1–February 14, representatives are available 7 days a week, 8 a.m.–8 p.m.). After hours and on holidays, please leave a message and a representative will return your call on the next business day.

[1]Tufts Health Plan Senior Care Options 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. 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.

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