TUFTS Health Plan

Tufts Medicare Preferred Member Reimbursement Form

This form allows Tufts Health Plan Medicare Preferred 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). **Please note:** 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 Vision Care.

If a Member Reimbursement 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 a Personal Representative before the request can be processed. You can find the AOR Form on our website at **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

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[1]
(e.g. asthma, lab work, ER visit, flu shot, eyewear, durable medical equipment,[2] dental work, 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.[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.

Signature

I attest that the information is accurate and complete.

Signature _____ Date _____

Instructions

Please mail this completed form to:

Tufts Health Plan Medicare Preferred
Attn: Member Reimbursement
P.O. Box 9183
Watertown, MA 02471-9183

For more information:

Call Customer Relations at **1-800-701-9000 (TTY: 711)**

[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 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.