MEMBER REIMBURSEMENT MEDICAL CLAIM FORM

(please complete one form per family member per provider)

US FAMILY HEALTH PLAN

Instructions

1. You will need your health care provider to assist and supply information in completing this form, including the procedure code(s) and diagnosis code(s). It is recommended that you bring it with you to your appointment. Please also refer to the Help Sheet for additional information.
2. To request reimbursement, please submit the following to the address listed at the bottom of this form (any missing information may result in delay or denial of the request):
   a. This completed and signed reimbursement form b. Proof of services rendered c. Proof of payment for the services being requested for reimbursement
3. Most completed reimbursement requests are processed within 30 days. Incomplete requests and requests for services that were rendered outside of the United States may take longer.
4. Reimbursement will be sent to the Plan subscriber (see Help Sheet for definition) at the address USFHP has on record (To view your address of record, please log on to usfamilyhealth.org or call Member Services at the number listed on the back of your ID card.)
5. If you are seeking reimbursement for a class such as childbirth, the class must be completed, a certificate of completion must be included, and the class must be paid in full prior to the reimbursement request. For lactation classes, please include the newborn's date of birth in the box next to the parent's date of birth.
6. Retain a copy of all receipts and documentation for your records.

Subscriber Information

Subscriber Last Name	First Name	Middle Initial

Patient Information

Patient's USFHP ID#	Patient's Email Address
	_____@_____

Patient's Last Name	First Name	Middle Initial

Date of Birth (MM/DD/YYYY)	Telephone Number
	_ _

Claim Information

(This section must be completed and you will need your health care provider to assist in completing this section.)

Health Care Provider's Name	Setting where treatment was received	Telephone Number	License# and State of License
		_ _	

Address	Were services received outside of the U.S.?
	❑ No, proceed to next question ❑ Yes, answer the following questions: In what country was the patient seen? _____ In what language was the bill written? _____ In what currency was the bill paid? _____

Diagnosis Codes	Diagnosis Description (e.g., flu, broken leg, manic-depressive disorder, asthma)	Date(s) of Service	Procedure Codes (for each service provided)	Procedure Descriptions (e.g., x-ray, office visit, lab work, leg cast, etc.)	Amount Paid
_____ ._____		____/____/____			$
_____ ._____		____/____/____			$
_____ ._____		____/____/____			$
_____ ._____		____/____/____			$
				Total amount paid	$

Patient signature is required

I attest that the above information is true and accurate and that the services were received and paid for in the amount requested as indicated above. I acknowledge that if any information on this form is misleading or fraudulent my coverage may be cancelled and I may be subject to criminal and/or civil penalties for false health care claims. I understand that reimbursement payment will be made to the Plan subscriber and will contain information about the service (e.g., provider name, date, description of service). I also understand that USFHP may request any additional information it deems necessary to verify that services were received and payment was made.

Printed name	Signature	Date

Checklist

- ❑ I have completed and signed this form in its entirety.
- ❑ I have enclosed proof of payment (see the help sheet for an example of proof of payment).
- ❑ I have enclosed proof of service (see the help sheet for an example of proof of service).
- ❑ I have included the certificate of completion for covered health education classes and the newborn's date of birth if needed.
- ❑ I understand that most completed reimbursement requests are processed within 30 days. Incomplete requests and requests for services rendered outside of the United States may take longer.

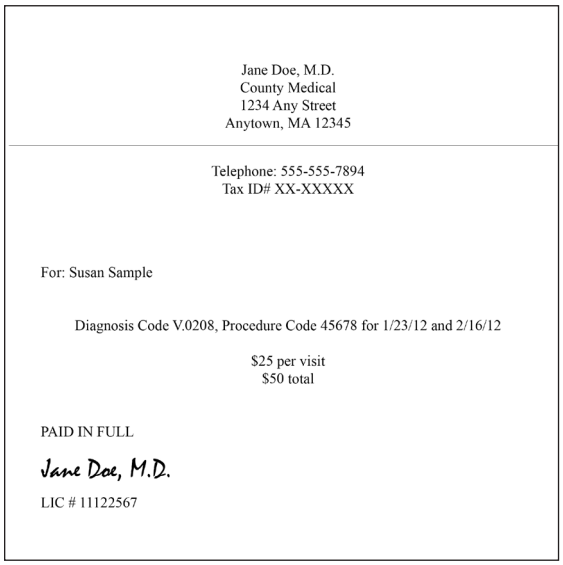
Please submit this form and all documentation to:

US FAMILY HEALTH PLAN • P.O. BOX 495 • CANTON, MA 02021-0495

MEMBER REIMBURSEMENT MEDICAL CLAIM FORM HELP SHEET

FIELD NAME	DESCRIPTION
Subscriber Information	Subscriber is the person: • who enrolls in USFHP and signs the membership application form on behalf of him/herself and any dependents. • in whose name the premium is paid.
Patient's USFHP ID#	ID# with suffix, found on the front of the USFHP ID card.
Patient's Name	Last and First names and Middle Initial of patient who received services.
Patient's Date of Birth	Date of birth: month (2 digits), day (2 digits), year (4 digits). Include newborn's date of birth in the same box as the parent's for lactation classes.
Provider's Name, Address, Telephone Number, License#, and State of License	A provider includes, but is not limited to, hospitals, physicians, optometrists, psychiatrists, licensed clinical social workers, Durable Medical Equipment suppliers, and pharmacies (for covered items that are not submitted to your pharmacy vendor).
In what setting did the patient receive treatment?	Such as office, emergency room, outpatient hospital (for X-rays, tests), inpatient hospital, clinic, medical supply store.
If services were rendered outside of the U.S.	If applicable, indicate in what country services were provided, in what language (if not English) the bill and proof of payment were written, and in what currency the bill was paid.
Diagnosis: What was the patient seen for?	Provide a diagnosis code and detailed description of illness or injury. (e.g., flu, broken leg, manic-depressive disorder, asthma)
Date(s) of Service	The date(s) the services were provided to the patient.
Procedures, Services, or Supplies Provided	Provide a procedure code and detailed description. (e.g., x-ray, office visit, lab work, leg cast, etc.)
Total Amount Paid	Total amount for which you are requesting reimbursement.
Proof of Service(s)	A document that demonstrates the service was actually rendered, listing date(s) of service, service(s) provided, and dollar amounts paid.
Proof of Payment	A document that demonstrates payment made by the member was received by the provider of service. Examples include: 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; a statement from the provider, on the provider's letterhead with authorized signature, indicating payment was made; a receipt for purchased items, with the provider's name and address preprinted on the receipt, with items listed and amount paid.

PROOF OF SERVICE AND PROOF OF PAYMENT EXAMPLES



Jane Doe, M.D.
County Medical
1234 Any Street
Anytown, MA 12345

Telephone: 555-555-7894
Tax ID# XX-XXXXX

For: Susan Sample

Diagnosis Code V.0208, Procedure Code 45678 for 1/23/12 and 2/16/12

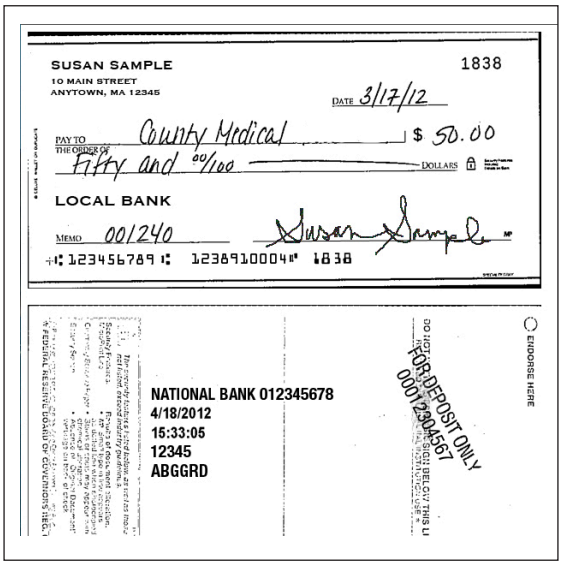
$25 per visit
$50 total

PAID IN FULL

Jane Doe, M.D.

LIC # 11122567

This example demonstrates both proof of payment and proof of service



SUSAN SAMPLE
10 MAIN STREET
ANYTOWN, MA 12345

1838

DATE 3/17/12

PAY TO THE ORDER OF County Medical $ 50.00

Fifty and 00/100 DOLLARS

LOCAL BANK

MEMO 00/1240

Susan Sample

⑆123456789⑆ 12389100004⑈ 1838

NATIONAL BANK 012345678
4/18/2012
15:33:05
12345
ABGGRD

FOR DEPOSIT ONLY
0001290A567

ENDORSE HERE

This example demonstrates proof of payment