MEMBER REIMBURSEMENT MEDICAL CLAIM FORM

(Please complete one form per family member per provider)

INSTRUCTIONS

1. Your health care provider will need to assist you in completing this form, including procedure code(s) and diagnosis codes(s). It is recommended that you bring this form with you to your appointment. Please refer to the Help sheet for more 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 this 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 the United States may take longer.
4. Reimbursement will be sent to the Plan subscriber (see Help sheet for definition) at the address Tufts Health Plan has on record. (To view your address of record, please log in to tuftshealthplan.com or call Member Services at the number listed on the back of your ID card)
5. Retain a copy of all receipts and documentation for your records.

SUBSCRIBER INFORMATION

Subscriber Last Name	First Name	Middle Initial

PATIENT INFORMATION

Patient's Tufts Health Plan 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. You will need your health care provider to assist you 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 U.S.? ☐ No –Go to next section ☐ Yes. Answer the following questions: 1. In what country was the patient seen? _____ 2. In what language is the bill written? _____ 3. In what currency was the bill paid? _____	

Diagnosis Code(s)	Diagnosis Description (e.g. flu, broken leg, bi-polar disorder, asthma, etc.)	Date(s) of Service (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 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 covered 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 Tufts Health Plan may request any additional information it deems necessary to verify that services were received and payment was made.

Printed Name _____ Signature _____ Date_____

Please submit this form and all documentation to:

TUFTS HEALTH PLAN • Attn: Member Reimbursement Area • Public Plans • P.O. Box 9194 • Watertown, MA 02471-9194