MEMBER REIMBURSEMENT MEDICAL CLAIM FORM

(one per patient per provider)

TUFTS Health Plan

Please print clearly, complete all sections and sign. Retain a copy of all receipts and documents for your records

1. Patient's Tufts Health Plan #
❑ HMO ❑ POS ❑ PPO ❑ CareLink

2. Patient's Name (Last, First, Middle Initial)

3. Patient's Date of Birth / /
sex: ❑ M ❑ F

4. Patient's Relationship to Subscriber
❑ Self ❑ Spouse ❑ Child ❑ Other

5. Subscriber's Name:
Address:
Telephone: ( ) -

6. Provider's Name:
Address:
Telephone: ( ) -
License # and State of License:_____

7. In what setting did the patient receive treatment?
(e.g.: office, ER, hospital, clinic, ambulance, etc.)

8. Outside the USA:
In what country was the patient seen? _____
In what language was the bill written? _____
In what currency was the bill paid? _____

9. DIAGNOSIS: What were you seen for? (e.g., flu, broken leg, asthma, manic-depressive disorder, etc.)
Diagnosis Code* _____ Description _____
Diagnosis Code* _____ Description _____
***Diagnosis Code required for Mental Health Services**

10.

A	B	C
Date(s) of service	**Procedure code and/or description of procedures, services, or supplies provided** (e.g.: x-ray, office visit, lab work, leg cast, etc.)	**Amount paid**
	*	
	*	
	*	

***Procedure Code required for Mental Health Services**

11. Total Amount Paid:_____

12. Proof of service(s) through one of the following:
❑ An itemized bill from the provider of service, listing dates of service, services provided, and dollar amounts paid;
❑ Bursar bill for student who received treatment from a school infirmary;
❑ Proof of class attendance for childbirth classes (including start and end dates) and copy of registration form, certificate of attendance, or a letter from the provider (required)

13. Proof of payment through one of the following:
❑ 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

14. Signature is required

I attest that the above information is true and accurate, and 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 also understand that Tufts HP may request any additional information it deems necessary to verify that services were received and payment was made.

_____

INTERNAL USE ONLY

Representative's Name/Extension: Corporate Receipt Date:

Please submit this form and all documentation to:
TUFTS HEALTH PLAN
MEMBER REIMBURSEMENT CLAIMS, PO BOX 9191
WATERTOWN, MA 02471-9191

MEMBER REIMBURSEMENT MEDICAL CLAIM FORM HELP SHEET

(one per patient per provider)

(Please print clearly when completing the medical claim form)

FIELD #	FIELD NAME	DESCRIPTION
1	Patient's Tufts Health Plan # and Plan Type	ID# with suffix, found on the front of the Tufts Health Plan ID card. Type enrolled in: HMO, POS, PPO, Liberty by Tufts Health Plan, powered by Destiny Health, or CareLink.
2	Patient's Name	Last, First, Middle Initial of patient who received services.
3	Patient's Date of Birth Patient's Sex	Date of Birth: Month (2 digits), Day (2 digits), Year (4 digits) Sex: M = Male, F = Female
4	Patient Relationship to Subscriber	Is the patient the subscriber, the spouse, the child or an other (e.g. partner)?
5	Subscriber's Name, address, and telephone #	Subscriber is the person: • who enrolls in Tufts Health Plan and signs the membership application form on behalf of him/herself and any dependents • in whose name the premium is paid. Subscriber's address must include zip code. Subscriber's telephone number must include area code.
6	Provider's Name, address, telephone #, license # and state of license	A provider includes, but is not limited to, hospitals, physicians, optometrists, psychiatrists, licensed clinical social workers, DME suppliers, and pharmacies (for covered items that are not submitted to your pharmacy vendor).
7	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
8	Outside the USA	If applicable, indicate in what country services were provided, in what language (if not English) the bill and proof of payment are written, and in what currency the bill was paid.
9	Diagnosis: What was the patient seen for?	• Diagnosis Code required for mental health services.* • For non-mental health services, provide a diagnosis code or detailed description of illness or injury.*
10A	Date(s) of Service	The date(s) the services were provided to the patient.
10B	Procedures, Services, or Supplies Provided	• Procedure Code required for mental health services.* • For non-mental health services, provide a procedure code or detailed description.* (e.g.: wig, birthing class, etc.)
10C	Amount Paid	Amount paid for each date of service and procedure listed.
11	Total Amount Paid	Total amount for which you are requesting reimbursement.
12	Proof of Service(s)	A document (see Member Reimbursement Medical Claim Form) from the provider listing date(s) of service, service(s) provided, and dollar amounts paid.
13	Proof of Payment	A document (see Member Reimbursement Medical Claim Form) that confirms your payment.
14	Signature is Required	SIGNATURE OF INDIVIDUAL COMPLETING FORM MUST BE INCLUDED: By signing the Member Reimbursement Medical Claim Form, you are certifying to us that the information is true, that the services were received and paid for in the amount requested, and that you understand that if any information on the form is misleading or fraudulent, your coverage may be cancelled and you may be subject to criminal and/or civil penalties for false health care claims. You are also certifying that you understand that Tufts HP may request any additional information it deems necessary to verify that services were received and payment made.

*As with all medical treatments, please consult with the provider office for an accurate code/description.