

USE THIS REQUEST FOR DIRECT REIMBURSEMENT FORM TO ASK FOR REIMBURSEMENT FOR ELIGIBLE CARE AND SERVICES THAT YOU HAVE ALREADY PAID FOR WITH A CREDIT CARD, CASH, OR CHECK.

This form cannot be used for reimbursement requests for non-eligible care or services. To ensure timely processing, please fill out all requested information and attach supporting documentation. Incomplete requests will be returned. Please complete one form for each individual reimbursement request.

IF YOU HAVE ANY QUESTIONS OR NEED HELP FILLING OUT THIS FORM, please contact our Member Services Helpline at: 1.866.986.0356 • TTY: 711, 7 days a week, 8am-8pm. If you need in-person assistance with filling out this form, please visit one of our Community Offices. For office locations, please visit our website at: www.metroplus.org/metroplus-near-you.

INSTRUCTIONS

SECTION 1 – MEMBER INFORMATION:

- ✓ Write your Member ID number, which is found on your member ID card
- ✓ Write your Group Number, which is found on your member ID card
- ✓ Write your Name as shown on your member ID card
- ✓ Write the number you want to be contacted at in case we need to verify any information.

SECTION 2 – REIMBURSEMENT DETAILS:

- ✓ Write in the date of service
- ✓ Check off reason for reimbursement
- ✓ Write all Provider details
- ✓ Write in the total that you paid out of pocket

SECTION 3 – SUPPORTING DOCUMENTATION:

Do not submit any original documents- only submit copies to MetroPlusHealth

- ✓ Please make sure your supporting documentation is clear and readable
- ✓ Please include proof of payment
 - Please do not send credit card receipts, cashed checks, or copies of checks. They are not acceptable receipts for reimbursement.
 - If you do not have proof of payment, please request a copy from the Provider
 - Reimbursement requests that do not include proof of payment may be dismissed
- ✓ Write your Member ID at the top of each page of any supporting documents

SECTION 4 – MEMBER ATTESTATION:

- ✓ Sign and date your form to certify the information on the form and in the documents are accurate and complete.

If you are acting as a Beneficiary Representative, be sure to complete and attach the Appointment of Representative Form, available at: <https://www.cms.gov/cms1696-appointment-representative>.

SECTION 1: MEMBER INFORMATION

First Name:	Last Name:	Member ID #:
Street Address:		Medicare ID #:
City, State, Zip:		Telephone #:

SECTION 2: REIMBURSEMENT DETAILS

Date of Service (MM/DD/YYYY): _____

I went to an out-of-network Provider (please explain): _____

I did not have my Member ID Card

I am requesting a transportation reimbursement

Gym reimbursement

Other (please explain): _____

PROVIDER INFORMATION

Provider's Name:		
Description of Care or Service:		
Date of Care or Service:	Amount Paid:	
Street Address:	City, State:	Zip:

PROVIDER INFORMATION

Provider's Name:		
Description of Care or Service:		
Date of Care or Service:	Date of Care or Service:	
Street Address:	Street Address:	Street Address:

PROVIDER INFORMATION

Provider's Name:

Description of Care or Service:

Date of Care or Service:

Date of Care or Service:

Street Address:

Street Address:

Street Address:

SECTION 3: SUPPORTING DOCUMENTATION

- Proof of payment
 Paid receipt of services
 Itemized receipts or claim form for services
 Copy of check or copy of money order receipt

SECTION 4: MEMBER ATTESTATION

You understand that if the services are deemed covered services, then the health plan will reimburse you up to the benefit amount minus any applicable deductible, coinsurance, or copayments. You understand that to process the claim we may need to disclose the information on the form to other persons and entities.

By signing below, I attest that I have paid the dollar amount listed below for the services received while a MetroPlusHealth Plan member. I further confirm that the documents attached to this form proving proof of payment are accurate, true, and complete. I understand that my request can be denied if I do not provide required documentation to support my request for reimbursement.

Sign Here ► _____ Date: _____

*If you are the authorized representative, you must sign above and provide the following information:

Name:	Relationship to Enrollee:
Street Address:	
City, State, Zip:	Telephone #:

Please check if you are the: **Member** OR **Beneficiary Representative**

If you are the Beneficiary Representative, please attach the required Appointment of Representation (AOR), Power of Attorney, or Executor of Estate form. The AOR form can be found at

<https://www.cms.gov/cms1696-appointment-representative>

Please submit entire form and all supporting documentation to:

**MetroPlusHealth • Att: Member Services
50 Water Street, 7th Floor • New York, NY 10004
Fax: 212.908.5196**

MetroPlus Medicare Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-866-986- 0356 (TTY: 711). **H0423_MEM22_2692_C 03042022 v2 Pg.3 of 3**