✓MetroPlusHealth

Medicare member request for direct reimbursement form

Use this form to ask us to pay you back for services you paid for.
Only certain services qualify under the plan's rules:

- ✓ **If you went to an out-of-network Doctor or Provider.**
- ✓ **You did not have your Member ID Card.**
- ✓ **You are asking to be paid back for a ride to the doctor.**
- ✓ **You are asking to be paid back for a gym membership.**

Please fill out this form completely and include any needed papers. If the form is not complete, we will have to return it. Please use one form for each service.

Questions? Need help filling out this form? Call 1.866.986.0356 • TTY: 711 Monday to Friday, 8am - 8pm and Saturday, 9am - 5pm. You can also get help in person. To find an office near you, **visit metroplus.org/metroplus-near-you .**

How to fill out this form:

Section 1 – Your information:

- ✓ Write your Member ID number. You can find it on your member ID card.
- ✓ Write your Medicare ID Number. You can find it on your member ID card.
- ✓ Write your Name as shown on your member ID card.
- ✓ Write the phone number we should use to reach you if we have questions.

Section 2 – What you paid for and why / Details about the service and why you paid for it:

- ✓ Write in the date of service.
- ✓ Check off reason you want to be paid back.
- ✓ Write all doctor or provider details.
- ✓ Write in the total that you paid.

Section 3 – Proof of payment:

Do not send original paperwork or receipts. Only send copies to MetroPlusHealth.

- ✓ Please make sure your paperwork is clear and readable
- ✓ Please include proof of payment
  - Please do not send credit card receipts, cashed checks, or copies of checks. We need proof from the Provider(s) who you paid.
  - If you do not have proof of payment, please ask the Provider for a copy.
  - If you do not include proof of payment, we may not be able to pay you back.
- ✓ Write your Member ID at the top of each page of any paperwork you send us.

Section 4 – Your signature:

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

Are you a Beneficiary Representative? (A person who can legally sign paperwork for another person.) Be sure to complete and include the Appointment of Representative Form. You can find it at: cms.gov/cms1696-appointment-representative.

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Section 1: Your information		
First Name:	Last Name:	Member ID #:
Street Address:		Medicare ID #:
City, State, Zip:		Telephone #:

Section 2: What you paid for and why / Details about the service and why you paid for it:
Date of Service (MM/DD/YYYY):

☐ I went to an out-of-network Doctor or Provider (please explain): ______________________________

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☐ I did not have my Member ID Card.

☐ I am asking to be paid back for a ride to the doctor.

☐ I am asking to be paid back for a gym membership.

☐ Other (please tell us why): ____

____

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

Doctor or Provider's information		
Provider's Name:		
Name of Care or Service:		
Date of Care or Service:	Date of Care or Service:	
Street Address:	City, State:	Zip:

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MetroPlusHealth

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

Section 3: Proof of Payment

- ☐ Proof of payment
- ☐ Copies of paid receipt of services
- ☐ Itemized copies of receipts or claim form for services

Section 4: Your Signature

You understand that if the plan covers these services, we will pay you back for part or all of the cost. The amount you get back depends on your plan. It may be lower because of a copay, coinsurance or deductible. We may need to share this information with other people or organizations in order to pay this claim.

When I sign below, I am saying that I have paid the dollar amount listed below for the services I got while a MetroPlusHealth Plan member. I also confirm that the proof of payment I provide is accurate, true, and complete. I understand that if I do not provide the correct paperwork the plan may not pay me back.

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 a Beneficiary Representative, please include one of these forms: Appointment of Representation (AOR), Power of Attorney, or Executor of Estate. You can find the AOR form at cms.gov/cms1696-appointment-representative.

Please send this form and all your paperwork 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).