

MEMBER REIMBURSEMENT FORM



Required Information

Last Name: _____ First Name: _____ Middle Initial: _____

Member ID #: _____ Date of Birth: ____ / ____ / ____
(M M / D D / Y Y Y Y)

Name of Provider of Service: _____ Date(s) of Service: _____

Phone Number and Address of Provider (if known): _____

In what setting did you receive treatment? (e.g. office, ER, hospital, clinic, etc.) _____

Use reverse side or another sheet of paper to include any additional information if necessary.

Amount of reimbursement you are requesting: \$ _____

Note: Any reimbursement made will be less applicable cost-sharing. See your benefits document for details.

If services were performed outside of the USA:

In what country were services performed? _____

In what language was the bill/receipt written? _____

In what currency was the bill paid? _____

Describe the items or services that you were seen for.¹

(e.g. asthma, lab work, ER visit, flu shot, eyewear, durable medical equipment², etc.)

Please include Proof of Payment AND Itemized Receipt³

Check which of the following acceptable proof of payment you are attaching to this form.

- A copy of 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 with itemized bill and authorization, if applicable.
- A statement from the provider, on the provider's letterhead with authorized signature, indicating payment was made.

¹ Tufts Medicare Preferred HMO requires prior authorization for certain drugs, devices, and equipment as a condition of payment. Refer to your Evidence of Coverage booklet for your plan's guidelines.

² Prescription may be required for Durable Medical Equipment purchase. See your benefit document for details.

³ A receipt for purchased items, with the provider's name and address preprinted on the receipt, with items listed and the amount paid.

continued >

MEMBER REIMBURSEMENT FORM



Signature is Required

I attest that the information is accurate and complete.

Member's Signature: _____ Date: _____

Tufts Health Plan
Medicare Preferred
Member Reimbursement
P.O. Box 9183
Watertown, MA 02471-9183

NOTE: For HMO members looking to submit for Wellness Allowance reimbursement, please use the Wellness Allowance Benefit Form. For Medicare Supplement members looking to submit for Fitness and Nutritional Counseling reimbursement, please use the Fitness and Nutritional Counseling Benefit Form. For HMO members looking for Eyemed reimbursement from a non-plan provider, please use the Out of Network Vision Services Claim Form.

Tufts Health Plan is an HMO plan with a Medicare contract. Enrollment in Tufts Health Plan depends on contract renewal.

Tufts Medicare Preferred Supplement plans are offered in accordance with Massachusetts law.

This information is available for free in other languages. Please call our Customer Relations number at 1-800-701-9000 (TTY 1-800-208-9562), Monday - Friday 8 a.m. - 8 p.m. (from Oct. 1 - Feb. 14 representatives are available 7 days a week, 8:00 a.m. - 8:00 p.m.).

Esta información está disponible de forma gratuita en otros idiomas. Comuníquese con nuestro departamento de atención al cliente al número 1-800-701-9000 para obtener información adicional. (Los usuarios de TTY deben llamar al 1-800-208-9562). El horario es de lunes a viernes, de 8 am a 8 pm (del 1 de octubre al 14 de febrero, los representantes están disponibles los 7 días a la semana, de 8 am a 8 pm).