MEMBER REIMBURSEMENT MEDICAL CLAIM FORM (**For Medical claims only** - please complete one form per family member per provider)

Instructions

1. You will need your health care provider to assist and supply information in completing this form, including the procedure code(s) and diagnosis code(s). Please refer to the Help Sheet for additional information.
2. To request reimbursement, please submit the following to the address listed at the bottom of this form within one year from date of service† (any missing information may result in delay or denial of the request):
a. This completed and signed reimbursement form b. Proof of services rendered c. Proof of payment for the services being requested for reimbursement d. Include itemized list of services or retail items for reimbursement review.
3. Most completed reimbursement requests are processed within 30 days. Incomplete requests and requests for services that were rendered outside of the United States may take longer.
4. Reimbursement will be sent to the Plan subscriber (see Help Sheet for definition) at the address Coordinated Care has on record (To view your address of record, please log on to coordinatedcarehealth.com or call Member Services at 1-877-644-4613 (TTY: 711).
5. Retain a copy of all receipts and documentation for your records.

Subscriber Information

Last Name:	First Name:	Middle Initial:

Patient information

Patient's Member ID#:	Last Name:	First Name:	Middle Initial:

Date of Birth (MM/DD/YYYY):	Mailing Address:

Telephone Number:	Patient Email Address:	Does Patient have additional insurance? ☐Yes ☐No	Did other Insurance make a payment: ☐Yes ☐No (**If yes, include plan's EOB)**

Other Insurance Company Name:	Other Insurance Company Phone Number:	Other Insurance Policy Number:

Claim Information

(This section must be completed and you will need your health care provider to assist in completing this section.)

Healthcare Provider's Name:	Healthcare Provider's NPI Number:	Healthcare Provider's Federal Tax ID #:	Healthcare Provider's Telephone Number:

Organization/ Group Name:	Organization/ Group NPI Number:	Organization/ Group Telephone Number:	Setting where treatment was received:

Healthcare Provider's Address:	Were services received outside of the U.S.? ☐Yes ☐No

Detailed explanation of illness/injury, including date(s) of injury/illness and explanation if a non-contracted provider was utilized:

Diagnosis Codes	Diagnosis Description (e.g., flu, broken leg, manic-depressive disorder, asthma)	Date(s) of Service	Procedure Codes (for each service provided)*	Procedure Descriptions (e.g., x-ray, office visit, lab work, leg cast, etc.)*	Amount Paid
.		/ /			$
.		/ /			$
.		/ /			$
.		/ /			$
					$

* Procedure and diagnosis codes may not be available for retail or foreign provider claims.

† One year requirement will be waived if you or your covered dependent member had no legal capacity to submit such proof during that year.

Coordinated Care Member signature is required **Total Amount Paid**

Coordinated Care of Washington, Inc. complies with applicable Federal civil rights laws and does not discriminate based on race, color, national origin, age, disability, or sex. Coordinated Care does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

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

Printed Name _____ Signature _____ Date _____

Checklist

1. I have completed and signed this form in its entirety.
2. I have enclosed documents of Proof of Services received (see the help sheet for an example of proof of payment).
3. I have enclosed documents of Payment of Services (see the help sheet for an example of proof of payment).
4. I understand that most completed reimbursement requests are processed within 45 days. Incomplete requests and requests for services rendered outside of the United States may take longer.

Please submit this form and all documentation to:
Coordinated Care • Claims Department-Member Reimbursement • P.O. Box 4030 • Farmington, MO 63640-4197

MEMBER REIMBURSEMENT MEDICAL CLAIM FORM - HELP SHEET / FAQs

Question	Answer
What is this form used for?	This form is used to ask for payment for eligible medical care you have already received and paid for when the provider of service refuses to bill Coordinated Care directly. This form should not be used for Vision, Dental or Pharmacy services.
What is my responsibility?	If you receive care from an out-of-network provider and the provider bills more than the Usual, Reasonable, and Customary charge, the member will be responsible (i.e. balance billed) for the sum of any amount that is over the Usual, Reasonable and Customary charge. **THIS IS NOT A GUARANTEE OF PAYMENT**. Actual payment for covered service will be paid at the appropriate level according to your plan benefits and you may be billed for the difference between Coordinated Care's allowed amount and the providers billed charges.
What if my service was completed out of the service area?	If you were temporarily out of the service area and had a medical or behavioral health emergency, be sure to report your emergency to us within one (1) business day. Routine or maintenance care is not covered outside the service area and will not be reimbursed unless pre-arranged with Coordinated Care prior to receiving services.
What happens next?	After processing your claim, a letter will be sent with the final claim determination and your Explanation of Benefits (EOB) will be available on the member portal. The EOB explains the payments made and any charges you may owe the provider. Please keep your EOB on file in case you need it in the future.
Did you know?	You receive a higher benefit if you use a Coordinated Care provider. This can be especially cost effective when receiving ongoing services like therapy services or when purchasing durable medical equipment.
Who should I contact if I need help with completing this form?	Contact Member Services at 1-877-644-4613 (TTY: 711).
Field Name	**Description**
Subscriber Information	Subscriber is the person: Who enrolls in Coordinated Care and signs the membership application form on behalf of him/ herself and any dependents. In whose name the premium is paid.
Patient's Member ID#	ID# with suffix, found on the front of the Coordinated Care Member ID card.
Patient's Name	Last and First names and Middle Initial of patient who received services.
Patient's Date of Birth	Date of birth: month (2 digits), day (2 digits), year (4 digits). Include newborn's date of birth in the same box as the parents.
Provider's Name, Address, Telephone Number, Provider Federal Tax ID #:	A provider includes, but is not limited to, hospitals, physicians, optometrists, psychiatrists, licensed clinical social workers, durable medical equipment suppliers.
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.
If services were rendered outside of the U.S.	If applicable, indicate in what country services were provided, in what language (if not English) the bill and proof of payment written, and in what currency the bill was paid.
Diagnosis: What was the patient seen for?	Provide a diagnosis code and detailed description of illness or injury. (e.g., flu, broken leg, manic-depressive disorder, asthma)
Date(s) of Service	The date(s) the services were provided to the patient.
Procedures, Services, or Supplies Provided	Provide a procedure code and detailed description. (e.g., x-ray, office visit, lab work, leg cast, etc.)
Total Amount Paid	Total amount for which you are requesting reimbursement.
Proof of Service(s)	A document that shows the service was provided, listing date(s) of service, service(s) provided, and dollar amounts paid.
Proof of Payment	A document that shows payment made by the member was received by the provider of service. Examples include: 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.

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