Mass General Brigham
Health Plan

Medical reimbursement

This checklist will guide you through the process of requesting a medical reimbursement. If your plan includes a fitness or weight loss benefit, please use the e-forms on the member portal under "Track costs and claims" to request a reimbursement.

I have completed and attached the following:

☐ Signed member reimbursement form with all sections clearly completed. This form is on the next page.

☐ For medical and/or behavioral health claims, an itemized provider bill that includes:

1. Provider information:
   - Provider name
   - Provider address
   - National Provider Identifier and/or Provider Tax Identification Number
2. Patient's name
3. Date(s) of service
4. Itemized charges for each date of service and type of service received
5. Procedure codes (CPT/HCPCS/revenue codes) for all services received
6. Number of units billed for each procedure code (CPT/HCPCS/revenue code)
7. Diagnosis code(s) for services received
8. If the claim is for services received outside of the United States, please include the name of the foreign currency (for example: euros, pesos, British pounds, etc.)

☐ Proof of payment:
   - Credit or debit card statement
   - Financial statement that includes a copy of the front and back of canceled check issued to the provider
   - Receipt of payment by provider for cash payments (all cash payments must include proof of source of funds, such as wire transfer, travelers check receipt, or bank statement)

Mass General Brigham Health Plan may contact providers to validate services rendered and/or payment amounts.

Most completed reimbursement requests are processed within 30 days. Incomplete requests and requests for services rendered outside of the United States may take longer.

Questions about this form? Call the customer service number on the back of your member ID card, or email **healthplanmedadvcustomerservice@mgb.org.**

Member Reimbursement Claim Form
for Medical Services

Mass General Brigham
Health Plan

1. Complete this form and checklist to request reimbursement when a provider bills you directly for a covered service.
2. Requests must be submitted within 12 months of the date of service.
3. Complete one form per family member and one form per claim.
4. Keep a copy of all receipts and documents for your records.

Mass General Brigham Health Plan reserves the right to request further information to support your claims.

A. Patient and Subscriber (Plan Holder) Information

1. Patient Member ID

2. Patient Name
First MI Last

3. Patient Date of Birth
Month Day Year

4. Patient Address

5. Relationship to Subscriber ☐ Subscriber

6. Subscriber ID Number

7. Subscriber
First MI Last

8. Subscriber Date of Birth
Month Day Year

9 Secondary Coverage: Does the patient have other insurance? ☐ Yes ☐ No
Name and ID number of the plan:

10. Was this claim due to an accident? ☐ Yes ☐ No

B. Provider or Hospital Information

11. Provider's Name

12. Contact Person *if available*

13. Provider Phone Number

14. Provider Address

15. Outside the United States
In what country was the patient seen? _____
In what language was the bill written? _____
In what currency was the bill paid? _____

C. Description of Services

16. Type of Service — *please check the type of service that was rendered*

☐ Behavioral health
☐ Office visit
☐ Inpatient hospital care
☐ Inpatient surgery
☐ Outpatient surgery
☐ Emergency room visit
☐ Lab or X-ray services
☐ Covered prescription drugs
☐ Medical supplies
☐ Other _____

17. Please describe what you were seen for/diagnosis. *(e.g., broken limb, sore throat, earache, etc.)*

18.

Date(s) of service	Description of procedures, services, or supplies provided	Amount paid

Please indicate total amount paid for services — *include total in foreign currency and the U.S. equivalent if necessary* _____

Please mail or fax this form and all documentation to:

Mass General Brigham Health Plan Claims Processing

399 Revolution Drive Suite 850 Somerville, MA 02145

Fax: 617-526-1902

I hereby apply for benefits and certify that the above information is complete, true, and correct. To all physicians and other medical professionals, hospitals, and other medical care institutions, and to insurers, medical or hospital service and prepaid health plans, employers and group policy holders, contract holders, or benefit plan administrators: You are authorized to provide the plan and any benefit plan administrators from consumer reporting agencies, attorneys, and independent claim administrators acting on the plan's behalf with information concerning medical care, advice, treatment, or supplies provided to the patient and any employment-related information regarding the Patient. This information will be used for the purpose of evaluating and administering claims for benefits. I understand that the duration of the authorization is for the term of coverage of the policy or contract under which a claim for health benefits has been submitted. I understand that I have a right to receive a copy of this authorization upon request. I agree that a photographic copy of this authorization is as valid as the original. It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, or a denial of insurance benefits.

Form must be signed. Claim cannot be processed without member's signature.

Member's signature Date

Subscriber's signature Date