

TUFTS Health Plan Medicare Preferred

MEMBER REIMBURSEMENT FORM

1. Member Name:	2. Member ID #:
3. Name of Provider of Service:	4. Telephone Number and Address of Provider (if known):
5. Date(s) of Service:	6. 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.	
7. Are you responsible for any co-payments, coinsurance, or deductibles for this service? No _____ Yes _____ Not Sure _____ Note: Any reimbursement made will be less applicable co-payments, coinsurance, or deductible.	
8. Amount of reimbursement you are requesting. \$ _____	
9. If services were performed outside the USA: In what country were services performed? _____ In what language was the bill/receipt written? _____ In what currency was the bill paid? _____	
10. What were you seen for? (e.g.: flu, broken leg, asthma, etc.)	
11. Describe the services that were provided to you. (e.g.: lab work, ER visit, flu shot, etc.)	
12. Please include Proof of Payment AND Itemized Receipt* Circle which of the following acceptable proof of payment you are attaching to this form. <ul style="list-style-type: none"> • 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. 	
*A receipt for purchased items, with the provider's name and address preprinted on the receipt, with items listed and the amount paid. *Prescription required for Durable Medical Equipment purchase.	
13. Signature is required I attest that the above information is accurate and complete. _____	
INTERNAL USE ONLY Claim # _____ Claims Status _____ Provider #: _____ Post Cataract Eyewear Procedure Codes _____	

NOTE: Do not use this form for Weight Watchers or Fitness reimbursement. For Weight Watchers reimbursement, use the Tufts Medicare Preferred Member Attendance Tracker form. For Fitness use the Fitness Reimbursement form.

**Tufts Health Plan Medicare Preferred
Customer Relations
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