



This claim form is used to request reimbursement of covered expenses. Complete the information below to tell us more about your request. See your Evidence of Coverage (EOC) for benefit guidelines and reimbursement allowable amounts.

MEMBER REIMBURSEMENT CLAIM FORM

Member ID or MBI Number: _____

Member's Name: _____

Member's Date of Birth _____

Member's Address _____

Member's Phone Number _____

Provider Name

(If the Physician is part of a Group, include the name of the Physician)

Provider NPI/ Tax ID Number (Provider should provide this information)

Provider telephone number _____

Date of service: (Example 09 02 2020) Month __ __ (Day) __ __ (Year) __ __ __ __

Condition or diagnosis: _____ CPT Code: _____
(Provider should provide this information)

Services Provided	\$ Charges	\$Paid Amount
Office Visit &/or Consultation	\$ _____	\$ _____
Radiology	\$ _____	\$ _____
Anesthesia	\$ _____	\$ _____
Hospital Services	\$ _____	\$ _____



Emergency Room Services	\$ _____	\$ _____
Laboratory	\$ _____	\$ _____
Surgery	\$ _____	\$ _____
Durable Medical Equipment	\$ _____	\$ _____
Mental Health	\$ _____	\$ _____
Other (description)	\$ _____	\$ _____

Please explain why you had to pay for the services:

Acknowledgement:

I certify that the information furnished in conjunction with this claim is true and correct. I know it is a crime to fill out this form with facts I know are false. I understand that submission of a claim is not a guarantee of payment of the full amount. If the services are deemed covered services then the health plan will reimburse me their cost share minus any applicable deductible, coinsurance, copayments and/or out-of-network member cost sharing. I understand that there will be no additional payments to the provider for this/these service(s).

Print Member/ Authorized Representative Name

Member/ Authorized Representative Signature

Date



*Authorized Representatives must complete an Authorized Representative form and submit it with this claim form or have valid legal documentation on record with the health plan.

INSTRUCTIONS FOR MEMBER REIMBURSEMENT CLAIM FORM

The reimbursement claim form must be submitted for all reimbursements.

Must be sure that the information included is correct. (Example: Member ID, date of service, etc.)

The following are the requirements to receive the reimbursement:

1. The form must be completed clearly.
2. Original receipt from provider including amount paid.
3. Name and telephone number of the provider.
4. Must include procedure code and diagnosis, using the corresponding code (ICD -10, CPT-4) and description and Provider name and NPI / Tax ID number. This should be available to you by contacting the servicing provider.

Please keep copy of the documents included in this claim.

Must be submitted on or before one (1) year after services rendered to the following address:

Provider Partners Health Plans
P.O. Box 94290 Lubbock, TX 79493
Attn: Direct Member Reimbursement

For questions or further information, please call our Member Service Department at our toll-free number 1- 800-405-9681 (TTY 711). Hours are 8:00 A.M. to 8:00 P.M., seven days a week from October 1 through March 31; 8:00 A.M. to 8:00 P.M. Monday to Friday from April 1 through September 30.