Member Reimbursement Medical Claim Form

(For medical claims only. Please complete one form per family member, per provider, per visit.)

A. 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). It is recommended that you bring it with you to your appointment. Please also refer to the help sheet on the next page for additional information.
2. To request reimbursement, please submit the following to the address listed at the bottom of this form (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.
3. Most completed reimbursement requests are processed within 45 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 AmeriHealth Caritas Next has on record. To view your address of record, please log on to **www.amerihealthcaritasnext.com/de** or call Member Services at **1-833-590-3300 (TTY 711)**.
5. Retain a copy of all receipts and documentation for your records.

B. Data elements

I. Subscriber information	
1. Last name:	
2. First name:	3. Middle initial:
4. Member ID number (subscriber ID and suffix):	5. Date of birth:
6. Mailing address:	
7. Phone number:	8. Email address:

II. Additional insurance
1. Does patient have additional insurance: ☐ Yes ☐ No
2. Did other insurance make a payment: ☐ Yes ☐ No (If “Yes,” include plan Explanation of Benefits.)
3. Other insurance company name:
4. Other insurance company phone number:
5. Other insurance policy number:

B. Data elements

III. Claim information	
1. Provider name:	
2. Setting where treatment was received:	
3. Phone number:	
4. Provider Federal Tax ID number:	5. Provider NPI number:
6. Provider address:	
7. Were services received outside the United States? ☐ Yes ☐ No	
8. Detailed explanation of illness/injury, including dates of injury/illness:	
9. Diagnosis code:	10. Diagnosis description:
11. Date of service:	
12. Procedure codes (for each service):	
13. Procedure description:	
14. Amount paid:	

C. 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. This form should not be used for vision, dental, or pharmacy services.
What is my responsibility?	Copayments, deductibles, coinsurance, and noncovered services will be the patient's responsibility.
What happens next?	After processing your claims, you will receive an Explanation of Benefits (EOB). The EOB explains the charges applied to your deductible (the fixed dollar amount you pay for covered services before the insurer starts to make payments) and any charges you may owe the provider. Please keep your EOB on file in case you need it in the future. You may also refer to your Member Handbook at **www.amerihealthcaritasnext.com/de**.
Did you know?	You receive a higher benefit if you use an AmeriHealth Caritas Next 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 **1-833-590-3300 (TTY 711).**

C. Help sheet/FAQs

Field Name	Description
Subscriber information	Subscriber is the person: — Who enrolls with AmeriHealth Caritas Next and signs the membership application form on behalf of himself/herself and any dependents. — In whose name the premium is paid.
Patient's AmeriHealth Caritas Next member ID number	ID number with suffix, found on the front of the AmeriHealth Caritas Next 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 the newborn's date of birth in the same box as the parent(s).
Provider's name, address, phone number, provider Federal Tax ID number:	A provider includes, but is not limited to, hospitals, physicians, optometrists, psychiatrists, licensed clinical social workers, and 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 the United States	If applicable, indicate in what country services were provided, in what language (if not English) the bill and proof of payment were 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, mental health condition, 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, laboratory work, leg cast).
Total amount paid	Total amount for which you are requesting reimbursement.
Proof of service(s) or superbill	A document that demonstrates the service was actually rendered, listing date(s) of service, service(s) provided, procedure code and description, diagnosis code and description, and dollar amounts paid.
Proof of payment	A document that demonstrates payment made by the member was received by the provider of service. Examples include: The front and back of the canceled 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 an 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.

D. Disclaimer

AmeriHealth Caritas Next complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. AmeriHealth Caritas Next 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 canceled 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 AmeriHealth Caritas Next may request any additional information it deems necessary to verify that services were received and payment was made.

1. Name (print):	
2. Signature:	3. Date:
4. Personal Representative:	

E. 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 — not related to copay or plan deductible (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.

F. Document submission

Please submit this form and all documentation to:

AmeriHealth Caritas Next
P.O. Box 7411
London, KY 40742-7411