Martin's Point

US FAMILY HEALTH PLAN

Reimbursement Request for Medical Services

See instructions on back of sheet.

A **Member Information**

Member Name: _____

Member Date of Birth: _____ Member ID Number: _____

B **Medical Information**

Health Care Provider/Company: _____

Date of Service: _____ Total Charge for Service: $ _____ Amount Paid: $ _____

C **Procedure Codes (if service received outside of US, provide description of service)**

Please provide all procedure codes: _____

D **Diagnosis Codes (if service received outside of US, provide description of service)**

Please provide all diagnosis codes: _____

E **If an accident, indicate date:** _____

F **Were you hospitalized?** _____ **If yes, hospital name and address:**

_____

G **Other Health Insurance Information**

Do you have other group health insurance coverage? _____

If yes, please provide the following:

Certificate or Membership ID Number: _____ Group Number: _____

Subscriber: _____

Insurance company name and address: _____

_____

Signature: _____

Instructions:

Please print required information as indicated below. Upon completion return to:

Martin's Point **US Family Health Plan**
Claims Department
PO Box 11410
Portland, Maine 04104-7410

1. **Complete Section A—**Member Number is printed on the US Family Health Plan Membership ID card.

2. **Complete Section B—**Enter the name of the physician, company, facility, or other health care professional from whom you received services; the date of the service; and the amount you paid.

3. **Complete Section C—**Provide all applicable procedure codes. Please ask your provider for applicable codes. If the service took place outside the US, please provide a description of the service.

4. **Complete Section D—**Provide all applicable diagnosis codes. Please ask your provider for applicable codes. If the service took place outside the US, please provide a description of the service.

5. **Complete Section E—**Enter the date of accident (if applicable)

6. **Complete Section F—**Enter the name and address of your other health insurance, if any, as well as the subscriber's name, and the certificate and group numbers of your policy. If you are asking to be reimbursed for multiple services, this information only needs to be filled out once, unless there was a change.

7. **Attach Evidence of Payment—**Attach a copy of your bill and the receipt of payment or canceled check.

8. **Attach Itemized Bill—**Copy of itemized bill **MUST** show: date of each service, place of service (doctor's office, inpatient hospital, outpatient hospital, patient's home, independent laboratory); description of each surgical or medical service or supply furnished; charge for EACH service; prescription/physician's order for medical equipment. It is helpful if the diagnosis is also shown on the provider's bill.

IMPORTANT: Incomplete information may result in a delay or denial of your claim. See above for reimbursement instructions.

- **Timely Filing—**To be eligible for reimbursement, you must submit this request to us **NO LATER** than one (1) year from the date of service listed in Section B on Page 1 of this form.
- Copies of proof of payment and itemized bill **MUST** be submitted to process your claim.