Member Reimbursement Form

The Member Reimbursement Form is not a guarantee of payment. Network Health reviews the coverage documents to ensure all provisions have been followed.

This form must be submitted within twelve (12) months of the date of service to be considered for reimbursement.

To be completed by the Member

Member Name: _____

Member ID Number: _____

Date of Birth: _____

Date of Service: _____

Medicare Advantage Member? ☐ Yes ☐ No

Please check one

*Special processing instructions apply

☐ Dental (For employer plans that have a dental reimbursement benefit. See your Certificate of Coverage for details.)

☐ Durable Medical Equipment (Must be purchased from a supplier that accepts Medicare)

☐ Emergency care outside of the United States
*If services were inpatient or surgical, medical records are required.

Reason for visit: _____

Date of visit: _____

Provider/facility name: _____

Were you admitted to the hospital (inpatient)? _____

Exchange rate for date of visit, in US dollars: _____

☐ Flu Shot

☐ Glasses after cataract surgery (See your Certificate of Coverage or Evidence of Coverage for details)

☐ Transplant lodging and transportation (mileage between your home and the designated transplant facility and between the lodging and transplant facility.)

☐ Other (please specify)

To ensure a faster claim review, please include the following required items.

- Receipt of payment
- DME Services must include prescription from your physician
- Vision hardware must include a copy of your new prescription

HMO and POS plans underwritten by Network Health Plan. Self-insured plans administered by Network Health Administrative Services, LLC. Y0108_**1817**-06-0723_C

To be completed by the Provider

**Please reach out to your provider for this information, or request your provider submit a claim directly to Network Health for consideration.

Provider Name _____

Tax Identification Number (TIN) _____

National Provider Identifier (NPI) _____

ICD-10 Diagnosis Code(s) _____

CPT/HCPCS Procedure Code(s)

Next Steps

Please ensure you have the following documentation.

- Completed Member Reimbursement Form
- **Paid** receipt for all services
  Please note – In order to qualify for reimbursement, receipts must show a zero-dollar balance, meaning the service or item has been paid in full
- Copy of prescription from your physician for any medical supplies and equipment, including glasses and diabetic shoes
- Lift chairs require the cost of the lift mechanism to be considered eligible

Please mail this form to:

Network Health
Attn: Claims Department
PO Box 568
Menasha, WI 54952

Or fax this form to: 920-720-1910

If you need assistance with this form or have any questions, please contact our member experience team at 800-378-5234 (TTY 800-947-3529), Monday-Friday from 8 a.m. to 8 p.m.

Member or Authorized Representative Signature

X	Date: