network health
1570 Midway Pl.
Menasha, WI 54952

Member Reimbursement Form

Include these items with your reimbursement request.

- This form, which must be completed within 12 months of the date of service to be considered for reimbursement
- A receipt of payment
- For vision hardware, please attach a copy of your new prescription
    - If you have a separate vision plan, eyewear not related to cataract surgery should be submitted to your vision plan
- A copy of the actual prescription from your doctor, which is required for processing durable medical equipment (DME) reimbursements
    - Lift chairs require the cost of the lift mechanism to be considered eligible

Please check one.

- ☐ Flu shot (Z23, 90656)
- ☐ Hearing aid (H90.3, V5140)
- ☐ Durable medical equipment (must be purchased from a DME supplier that accepts Medicare)
- ☐ Transplant lodging and transportation (mileage between your home and the designated transplant facility and between the lodging and transplant facilities)
- ☐ Emergency care outside the United States (include an English translation of medical records)
- ☐ After cataract or Medicare covered eyewear
- ☐ Other:

_____

_____

_____

To be completed by the member.

Member Name: _____ Member ID #: _____

Date of Birth: _____ Date of Service: _____

To be completed by your provider. (Please reach out to your provider to obtain this information, which is required to process your request.)

Provider name: _____

ICD 10 (Diagnosis) Code: _____ CPT Code: _____

NPI #: _____ Tax ID: _____

Taxonomy Code: _____

STOP

Before sending, please ensure you have the following documentation.

- Completed Member Reimbursement Form
- Copy of prescription from your doctor for any medical supplies, including glasses and diabetic shoes
- Paid receipt for all services
    - Remember, receipts must be translated to English and US dollars; if you paid with a credit card, the statement should provide the conversion rate
- In order to qualify for reimbursement, receipts must show a zero-dollar balance, meaning the service or item has been paid in-full

Please mail this form to: Network Health Medicare Advantage Plans
Attn: Claims Department
PO Box 120
Menasha, WI 54952

Or send by fax to: 920-720-1905

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