



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.**

- |   |   |
|---|---|
| <input type="checkbox"/> Flu shot (Z23, 90656)  | <input type="checkbox"/> Emergency care outside the United States (include an English translation of medical records) |
| <input type="checkbox"/> Durable medical equipment (must be purchased from a DME supplier that accepts Medicare)  | <input type="checkbox"/> After cataract or Medicare covered eyewear   |
| <input type="checkbox"/> Transplant lodging and transportation (mileage between your home and the designated transplant facility and between the lodging and transplant facilities) | <input type="checkbox"/> Other:<br>_____<br>_____<br>_____  |

**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 and equipment, 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  
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.