MEMBER REIMBURSEMENT MEDICAL CLAIM FORM

(For Medical claims only - please complete one form per family member per provider

Instructions

Subscriber Information

- 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 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 (i.e. Itemized Bill) c. Proof of payment for the services being requested for reimbursement
- 3. Most completed reimbursement requests are processed within 30 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 Ambetter from Sunshine Health has on record (To view your address of record, please log on to Ambetter.SunshineHealth.com or call Member Services at 1-877-687-1169 (Relay Florida: 1-800-955-8770)
- 5. Retain a copy of all receipts and documentation for your records.

Last Name:	ast Name:		First Name	:		Middle Init	Middle Initial:		
				Patient	information				
Patient's Ambetter Member ID#: Last		Last Nam	e:		First Name:		Middle Initial:		
Data of Birth (MM/DD/X	·///·			Mailing Ac	Maraga:				
Date of Birth (MM/DD/YYYY): Telephone Number: Patient		Patient E	Mailing Address:		Does Patient have additional insurance? □Yes □No		Did other Insurance make a payment: ☐Yes ☐No (If yes, include p EOB)		
Other Insurance Company Name:			Other Insurance Company P		Phone Number:	Other Insuran	rance Policy Number:		
		<u> </u>			Information				
		section must be	completed and you	ı will need you	r health care provider to assist	in completing this se			
Healthcare Provider's Name: Setti		Setting where tre	eatment was recei	ved:	Telephone Number:		Provider Federal Tax ID #:		
Healthcare Provider's Address:			<u>'</u>			Were services received outside of the U.S.? □Yes □No			
Detailed explanation of illness	s/injury, includin	g date(s) of inju	ry/illness:						
Diagnosis Codes Diagnosis De (e.g.,flu,broker depressive dis asthma)		kenleg, manic-		of Service	Procedure Codes (for each service provided) Procedure (e.g., xray, lab work ,le etc.)		fice visit,	Amount Paid	
·			/	/				\$	
			/	/				\$	
			/	/				\$	
•			/	/				\$	
Ambetter Member signatu	re is required					Tota	al Amount Paid	\$	
			•		not discriminate on the basis		ional origin, ag	e, disability, or sex. Ambetter from	
I attest that the above information	ation is true and	accurate and th	nat the services we	ere received a	nd paid for in the amount requ	ested as indicated	above. I acknow	wledge that if any information on	
payment will be made to the	Plan subscriber	and will ontain in	nformation about t	he service (e.	criminal and/or civil penalties g., provider name, date, descr e received and payment was	iption of service). I		rstand that reimbursement d that Ambetter from Sunshine	

Checklist

Signature

I have completed and signed this form in its entirety.

Printed Name

- I have enclosed documents of Proof of Services received (see the help sheet for an example of proof of payment)
- 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 have enclosed documents of Medical Records (Foreign claims must also include the applicable medical records translated in English)

Date

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.

Please submit this form and all documentation to:

Ambetter from Sunshine Health • Claims Department-Member Reimbursement • P.O. Box 5010 • Farmington, MO 63640-5010

MEMBER REIMBURSEMENT MEDICAL CLAIM FORM - 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 non-covered services will be patient responsibility. If you receive care from an out-of-network provider and the provider bills more than the Usual, Reasonable, and Customary charge, the member will be responsible (i.e. balance billed) for the sum of the co-insurance amount and any amount that is over the Usual, Reasonable and Customary charge. THIS IS NOT A GUARANTEE OF PAYMENT. Actual payment for covered service will be paid at the appropriate level according to your plan benefits and you may be billed for the difference between Ambetter from Sunshine Health allowed amount and the providers billed charges.			
What if my service was completed out of the service area?	If you were temporarily out of the service area and had a medical or behavioral health emergency, be sure to report your emergency to us within one (1) business day. Depending on your plan type, copayments may apply for emergency care received in an emergency room.Routine or maintenance care is not covered outside the service area and will not be reimbursed unless pre-arranged with Ambetter prior to receiving services.			
What happens next?	After processing your claims, you will receive an Explanations 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 on Ambetter.SunshineHealth.com.			
Did you know?	You receive a higher benefit if you use an Ambetter from Sunshine Health 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 1-877-687-1169 (Relay Florida: 1-800-955-8770)			
Field Name	Description			
Subscriber Information	Subscriber is the person: Who enrolls in an Ambetter from Sunshine Health and signs the membership application form on behalf of him/ herself and any dependents. In whose name the premium is paid.			
Patient's Ambetter Member ID#	ID# with suffix, found on the front of the Ambetterfrom Sunshine Health Member IDcard.			
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 newborn's date of birth in the same box as the parent's.			
Provider's Name, Address, Telephone Number, Provider Federal Tax ID #:	A provider includes, but is not limited to, hospitals, physicians, optometrists, psychiatrists, licensed clinical social workers, 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 of the U.S.	If applicable, indicate in what country services were provided, in what English) the bill and proof of payment 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, manic depressive disorder, 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, lab work, leg cast, etc.)		
Total Amount Paid	Total amount for which you are requesting reimbursement.		
Proof of Service(s)	A document that demonstrates the service was actually rendered, listing date(s) of service, service(s) provided, 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 cancelled 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 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.		
	Please submit this form and all documentation to:		

Ambetter from Sunshine Health • Claims Department-Member Reimbursement • P.O. Box 5010 • Farmington, MO 63640-5010

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