Medical Reimbursement Request Form

UnitedHealthcare Medicare Plus

You can use this form to ask us to pay you back for covered medical care and supplies. This includes medical, dental, vision, hearing, and foreign travel care and supplies.

- Check your plan materials to find out what your plan will pay for.
- Print your responses in black ink.
- Fill out a separate form for **each** member and **each** provider.
- Include billing statements from your doctor or supplier for each item. It should include a full description of the service or supplies received.
- Include proof of payment (such as a paid receipt, invoice, or a provider statement) for each item.
- For foreign travel, fill out one form for each member for the entire trip.
- You can use this form for both medical and prescription drugs for foreign travel.
- Send the completed form and paperwork to the **Medical Claim Address** on the back of your member ID card. You can find the address in the **For Providers** section on the back of your card.

Information about the member who received medical services or supplies

Full name _____

Address _____

City _____ State _____ ZIP _____

Phone number (_____) _____ ☐ Male ☐ Female

Date of birth _____

Member ID number _____ Member Group number _____

Information about other insurance coverage

Please tell us if you have other insurance, such as Travel, Veterans benefits or other employer insurance. Send us a copy of the insurers' Explanation of Benefits that includes the medical care or supplies you are asking us to reimburse. This will help us determine who pays first (primary responsibility) and who pays second (secondary responsibility).

Name of Insurance	Policy Number

Has workers' compensation refused to cover your accident or injury? ☐ Yes ☐ No ☐ NA

If yes, please send us a copy of your Explanation of Benefits or paperwork from a lawyer or workers' compensation saying that it doesn't cover your illness or injury. Check 'NA' (Not Applicable) if you did not submit for coverage.

Has your auto insurance policy refused to cover your accident or injury? ☐ Yes ☐ No ☐ NA

If yes, please send us a copy of the paperwork from the auto insurance company or a lawyer saying that it doesn't cover your illness or injury. Check 'NA' (Not Applicable) if you did not submit for coverage.

Information about your frames or lenses

Are you submitting for a routine eyewear reimbursement? ☐ Yes ☐ No

Are you submitting for a cataract benefit? ☐ Yes ☐ No

If submitting for a cataract benefit, what was the date of the surgery: _____

Where did you get medical care or supplies?

☐ Doctor's office ☐ Urgent care ☐ Emergency room ☐ Home

☐ Clinical lab ☐ Hospital ☐ Equipment supplier

☐ Assisted living facility or nursing home ☐ Independent imaging center

☐ Other _____

Doctor who ordered medical care or supplies

Name _____

Address _____

City _____ State _____ ZIP _____

Doctor or facility who provided care or service

Name _____

Address _____

City _____ State _____ ZIP _____

Did you get dialysis outside of the plan's service area? ☐ Yes ☐ No

Check 'No' if you are enrolled in the UnitedHealthcare Senior Supplement plan.

Medical care or supplies you received on a cruise or traveling to a foreign country

Type of travel: ☐ Cruise ☐ Foreign country

Note: Puerto Rico, U.S. Virgin Islands, Guam, the Northern Mariana Islands, Saipan, Tinian, Rota, or American Samoa are U.S. territories, not foreign countries.

Foreign services must be medically necessary. Please describe the situation that required the services that were provided.

_____

What city and country were you in when you received medical care or supplies?

_____

What currency were you billed in? _____

What currency did you pay in? _____

- Did you get a discount or refund from the provider? ☐ Yes ☐ No
  If yes, how much? _____
- Did you pay a copay or coinsurance? ☐ Yes ☐ No
  If yes, how much? _____

If you received care or supplies on a cruise or traveling to a foreign country, you must include a copy of your travel plan or itinerary.

Member signature

Signature _____ Date _____

When I sign above, I am stating that the information on this form is correct, to the best of my knowledge. I understand that if I put information on this form that I know is not true, I could face fines and prison under federal law.

☐ **Check this box if you're signing on behalf of the member.**

If I sign for the member, it means I have the legal right under state law to sign. I can show written proof of this right if Medicare asks for it.

If you are completing this form for the member, please provide your name, address, and phone number

Full name _____

Address _____

City _____ State _____ ZIP _____

Phone number (_____) _____

What is your relationship to the member?

☐ Spouse or partner ☐ Relative ☐ Attorney ☐ Estate representative ☐ Other _____

Have you been appointed or designated to act as a representative for the member? ☐ Yes ☐ No

If you answered yes, you must include paperwork when you submit this form showing you have the legal right to act for the member (such as Power of Attorney or Medicare's Appointment of Representative Form). You can find the Appointment of Representative Form on the plan's website, included with this form or you can call Customer Service and ask them to send you the form.

If you answered no, all communication and activity regarding this claim will be sent to the member only.

Details about the medical care or supplies you paid for

Fill out this chart to tell us what you paid for. You can find this information on your doctor or supplier's bill or you can call their office and ask them for the information. The services or supplies must be from a provider that is eligible to participate in Medicare. We've provided an example on the first line to help you complete the chart. Fill out a separate line for each service charge. If you need more room, you can use a separate piece of paper. For each service, you will need to include:

- A billing statement from your doctor/supplier for the services or supplies received.
- Proof of payment, such as a paid receipt, invoice, or a provider statement. The proof of payment must include the following information:
    - ○ The service you received
    - ○ The cost of the service (billed amount)
    - ○ The amount that you paid
    - ○ The date that you paid
    - ○ How you paid (check, credit card, etc.)

Date of service	Diagnosis or illness	Description of service or supply	Number of items or visits	Billed amount	Amount you paid	Proof of payment included?
1/15/20XX	Diabetes **(Example)**	Office visit **(Example)**	1	$123.00	$123.00	☒ Yes ☐ No
						☐ Yes ☐ No
						☐ Yes ☐ No
						☐ Yes ☐ No
						☐ Yes ☐ No
						☐ Yes ☐ No

☐ I have included a separate sheet of paper with additional details and other information I think will be helpful when processing my reimbursement.

Ready to send the completed form?

Please send the completed form and paperwork to the **Medical Claim Address** on the back of your member ID card. You can find the address in the **For Providers** section on the back of your card.

Before you put it in the mail, make sure you:

- Completed and signed the form.
- Include copies of all the paperwork we asked for, including:
    - Billing statements from your doctor or supplier for each line item above. It should include a full description of the service or supplies received.
    - Proof of payment such as a paid receipt, invoice, or a provider statement for each line item above.
    - Explanation of Benefits from other insurer, if applicable.
    - Travel plan or itinerary (UnitedHealthcare Senior Supplement only).
    - Power of Attorney or Appointment of Representative form, if applicable.
- Keep a copy of everything you send us.
- Request reimbursement within 1 year from the date of service. We may not be able to process your reimbursement after that time.

We will process your request based on your plan benefits. When completed, we will send you a check or a follow-up letter.

Questions? We're here to help.

Call the toll-free Customer Service number on the back of your member ID card.

Plans are insured through UnitedHealthcare Insurance Company or one of its affiliated companies, a Medicare Advantage organization with a Medicare contract and a Medicare-approved Part D sponsor. Enrollment in the plan depends on the plan's contract renewal with Medicare.
The company does not discriminate on the basis of race, color, national origin, sex, age, or disability in health programs and activities.

We provide free services to help you communicate with us. Such as, letters in other languages or large print. Or, you can ask for an interpreter. To ask for help, please call the member toll-free phone number listed on your ID card.

ATENCIÓN: Si habla español (Spanish), hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al número de teléfono gratuito que aparece en su tarjeta de identificación.

請注意：如果您說中文(Chinese)，我們免費為您提供語言協助服務。請撥打會員卡所列的免付 費會員電話號碼。