2024 Direct Member Reimbursement Request Form

For Medicare plan members

Medical Services

A	HERE'S HOW TO COMPLETE THIS FORM
	Use this form to submit a reimbursement request for service(s) covered under your medical plan if*: • You received emergency or urgent medical care from a provider who isn't in your plan's network • A network provider sent you a bill you think you shouldn't pay • You are retroactively enrolled in your plan, and you paid out of pocket for any of your covered services after your enrollment date
	1. Fill out sections 1 - 8. 2. Please remember: To receive reimbursement, you must attach copies of your itemized receipt(s) and proof of payment to this form. 3. Mail this completed form with attached receipt(s) to the address for your plan type. Plan types can be found on the front of your Medica ID card.
	Note: Please submit one (1) request per reimbursement form. If you have more than one service to submit, please fill out separate forms for each request.
	For Medica Advantage Solution® (HMO-POS, PPO), Medica Advantage℠ (PPO) + Medica Group Advantage Solution℠ (PPO) Plans Medica Claims P.O. Box 21342 Eagan, MN 55121 Or **For Medica Prime Solution® (Cost) + Medica Group Prime Solution℠ w/Rx (Cost) Plans** Medica Claims P.O. Box 30990 Salt Lake City, UT 84130
	Note: For reimbursement requests related to Chiropractic services, review your Explanation of Coverage for instructions on where to submit the claim.
	Please allow 60 calendar days from the date Medica receives your form for your reimbursement check to be mailed to you. Reimbursement requests must be made within 365 days from the date of service.

*Liability for your claim will be determined based on your plan and the information you supply.

1	MEMBER INFORMATION	
	Member name (as it appears on your Medica ID card):	
	Date of birth: ___ / ___ / _____	Phone number:
	Medica ID number:	Group number:

2	OTHER INSURANCE INFORMATION	
	Is the patient covered by another plan? ❍ Yes ❍ No	
	If Yes, please complete the following and provide the Explanation of Benefits (EOB) from the other insurance carrier. If you do not have an EOB, please submit your claim to the other carrier first. If No, please skip to section 3.	
	Name of person carrying other insurance:	Date of birth: ___ / ___ / _____
	Employer name if applicable:	Member ID number:

3	VISIT INFORMATION
	❍ Office ❍ Hospital – outpatient ❍ Urgent care ❍ Emergency room ❍ Home ❍ Other_____
	❍ Hospital – inpatient: Date of admission ___ / ___ / _____ Date of discharge: ___ / ___ / _____
	To help you complete this section, we're including a description of the information needed - you may get the information from the provider you visited. • Diagnosis Code: A code used to identify diseases, disorders, or health conditions. Must be in ICD or CM format. Multiple diagnosis codes may be submitted • Service Code: A code used to identify the procedure, service, or supply you received • Modifier: A 2-digit code used in addition to the Service Code to indicate that a service, or supply was distinct or independent from other services performed on the same day • UOS/MOS (Unit of Service / Minute of Service): The number of medical visits or procedures, units of anesthesia time, oxygen volume, items or units of service, etc. you received

Date(s) of service:	Diagnosis code(s):	Service code(s):	Modifier:	UOS / MOS:	Billed amount $:
___ / ___ / _____					
Date(s) of service : ___ / ___ / _____	Diagnosis code(s):	Service code(s):	Modifier:	UOS / MOS:	Billed amount $:
Date(s) of service: ___ / ___ / _____	Diagnosis code(s):	Service code(s):	Modifier:	UOS / MOS:	Billed amount $:
Date(s) of service : ___ / ___ / _____	Diagnosis code(s):	Service code(s):	Modifier:	UOS / MOS:	Billed amount $:
Date(s) of service : ___ / ___ / _____	Diagnosis code(s):	Service code(s):	Modifier:	UOS / MOS:	Billed amount $:
Member paid amount (US $)		$:			

4	**PROVIDER INFORMATION** (Contact your provider's billing department for assistance)			
	Facility / billing provider information:			
	Name:			
	Provider street address :	City:	State:	ZIP code:
	Provider federal tax identification number (TIN):	National provider identifier (NPI):		
	Physician/servicing provider information:			
	Name:			
	Provider street address:	City:	State:	ZIP code:
	National provider identifier (NPI):			

5	**FOREIGN SERVICES TRAVEL INFORMATION** (only complete this section if you received services outside U.S. territories*)			
	Date you left U.S.A: ___ / ___ / _____	Intended duration of trip:	U.S. Departure airport/ cruise port:	U.S. Return airport/ cruise port:
	Purpose of trip:			
	Description of foreign address at time of medical treatment: ❍ Hotel ❍ Resort ❍ Other:_____ Name of hotel or resort:_____			
	Street address:		City:	Country:
	Did you seek treatment due to an emergency? ❍ Yes ❍ No			
	Consider your visit an emergency if your condition required immediate treatment (generally provided at the onset of a condition) to: • Preserve your life • Prevent serious impairment to your bodily functions, organs, or parts • Prevent placing your physical or mental health in serious jeopardy Note: Scheduled visits as well as follow up visits are not considered an emergency			
	What prompted you to seek medical care?			
	Please provide details of accident or illness:			
	Name and address of witnesses:			
	Date of accident or illness began:			

*U.S. territories include American Samoa, Guam, Northern Mariana Islands, Puerto Rico, and U.S. Virgin Islands.

I certify that all information provided on this claim form is accurate to the best of my knowledge. I request payment be issued directly to me, unless Medica is required to pay the provider directly. I also certify, to the best of my knowledge, the expenses I am submitting meet the requirements of qualified expenses as covered by my plan. I further certify that these expenses are not reimbursable under any other plan and have not been reimbursed by any other plan.

Authorization: On behalf of myself, I authorize any health care professional or entity, employer, union, insurance company, health maintenance organization, other health plan company or prepayment organization to give Medica or any of its designees, any and all records or information pertaining to medical history or services rendered to me for evaluation of this request, and for any analytical or research purposes. This authorization will automatically expire one year from the date of signature unless I revoke it sooner.

A person who files a reimbursement request with the intent to defraud or helps commit fraud against an insurer is guilty of a crime.

Please check to see that this form has been properly completed and signed before submitting to Medica.

6	SIGNATURE	
	Member signature: X _____	Date: ___ / ___ / _____

7	PREFERRED LANGUAGE
	(If applicable) please provide your preferred spoken language below. This information will only be used for this reimbursement request if verbal outreach is necessary to obtain any missing or unclear details.
	Member preferred language:

8	REQUIRED DOCUMENTATION
	When submitting this medical service claim form, you must include: • The bill you received from your provider which should include the date of service, place of service, procedure and diagnosis code(s), and charge amount by line • Documentation of any payment you have made (can't be a balance due statement) Note: Documentation submitted with your claim will not be returned. Please make copies if needed. • Proof of travel for foreign claim submissions that shows your date(s) and location(s) of travel, for example: airline ticket receipt, boarding pass, itinerary and hotel bill, or travel visa
	Number of pages submitted with this form: _____

Have questions? We're here to help.

Call the Member Services number on the back of your Medica ID card. Visit **Medica.com/Forms** for additional copies of this form.