MEMORIAL HERMANN Health Plan
MEMORIAL HERMANN *ADVANTAGE* HMO

Member Reimbursement Form

Section A - Member Information (Please print)

Member ID Number:		Phone Number:
Last Name:	First Name:	MI:
Address:		
City:	State/Zip Code:	Date of Birth: MM DD YYYY

Section B - Reimbursement Information (Please print) Complete this section to assist us in processing the claim. Please include a copy of your bill and receipt of payment.

Were the services related to cataract surgery? Y N

Date of Service	Service Provider NPI/Tax ID Number	Service Description	Charged Amount	Paid Amount
	Name: NPI/Tax ID:			
	Name: NPI/Tax ID:			
	Name: NPI/Tax ID:			
	Name: NPI/Tax ID:			

Section C - Subscriber Certification

Acknowledgement:

I certify that the information furnished in conjunction with this claim is true and correct. I know it is a crime to fill out this form with facts I know are false. I understand that submission of a claim is not a guarantee of payment of the full amount.

If the services are deemed covered services then the health plan will reimburse me their cost share minus any applicable deductible, coinsurance, copayments and/or out-of-network member cost sharing. I understand that there will be no additional payments to the provider for this/these service(s).

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Member/Authorized Representative Signature* Date

*Authorized Representatives must complete an Authorized Representative form and submit it with this claim form or have valid legal documentation on record with the health plan.

HOW TO COMPLETE THIS REIMBURSMENT FORM

1. Member/Authorized Person must complete the following sections of the form:

- Member Information, Reimbursement information, and Subscriber Certification sections
- Signature of the Member or Authorized Representative. The form must be signed to process.
- Proof of Payment that shows your name must be attached, i.e., Doctor's Receipt, Credit Card Receipt, Cancelled Check (front and back}, etc.

Note: Please be sure to include all of the required information for your request to be processed without delay.

2. Submit the claim form:

Reimbursement request must be submitted within 365 days of the date of service. Failure to submit the medical claims within the 365 days would require you to submit a written appeal to your health plan showing good cause for the delay in filing request for reimbursement.

Please contact Customer Service at the number listed on the back of your ID card if you have any questions about completion of this form or if you wish to file an appeal. Appeals instructions are included in your Evidence of Coverage.

Mail completed form and proof of payment to:

Memorial Hermann Health Plan
ATTN: Claims Department - Member Reimbursement
929 Gessner, Suite 1500
Houston, Texas 77024

3. Reimbursement:

When we receive your request for payment, we will let you know if we need additional information from you. We will consider your request and decide whether to pay it and how much we owe. If the services are approved we will pay you the plan allowance minus any applicable deductible, coinsurance, copayments and/or out-of-network member cost sharing.

If we decide that the reimbursement request is not eligible, or you did not follow all of the plan rules, reimbursement may be denied. You will receive a written explanation of benefit(s) with the reason(s) for the denied payment and your rights to appeal that decision, as explained above.

Memorial Hermann *Advantage* HMO is provided by Memorial Hermann Health Plan, Inc., a Medicare Advantage organization with a Medicare contract. Enrollment in this plan depends on contract renewal.

Memorial Hermann *Advantage* complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex.

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 855-645-8448 (TTY 711).
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phídành cho bạn. Gọi số 855-645-8448 (TTY 711).