

MEMBER REIMBURSEMENT MEDICAL CLAIM FORM

(Please complete one form per family member, per provider)

INSTRUCTIONS

1. You will need your health care provider to assist and supply information in order to complete this form. It is recommended that you bring this form with you to your consultation visit. Please also refer to the Help Sheet for additional information.
2. Please submit the completed Reimbursement Medical Claim Form along with the additional documents and receipts to the BMC HealthNet Plan as soon as possible. The following documents are required.
 - a. Member Reimbursement Medical Claim Form (Completed and Signed)
 - b. Proof of services rendered (Itemized bill or invoice)
 - c. Proof of payment for the services being requesting for reimbursement (Receipt, bank statement, invoice with payment details. For childbirth classes, include a certificate of course completion.)
3. The reimbursement review process takes approximately 4 to 6 weeks to complete.
4. Reimbursement will be sent by mail to the Plan subscriber at the address BMC HealthNet Plan has on record.
5. Keep a copy of all receipts and documents for your own records.
6. **Timely Filing Limit:** Submit the form with receipts within 6 months from the date of service for QHP and ConnectorCare members. There is no filing limit for MassHealth members.

SUBSCRIBER INFORMATION

Subscriber Last Name

First Name

Middle Initial

PATIENT INFORMATION

Patient's BMC HealthNet Plan ID#

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Patient's Last Name

First Name

Middle Initial

Date of Birth (MM/DD/YYYY)

Telephone Number

Email Address

CLAIM INFORMATION

(This section must be completed. Your health care provider can assist in completing this section.)

Health Care Provider's Name and Address

Setting where treatment was received:

- ☐ Outside the U.S. (describe in box below)
- ☐ Hospital/Urgent Care Outside the Service Area
- ☐ Hospital/Urgent Care Inside the Service Area
- ☐ Doctor's Office
- ☐ Laboratory/High Imaging
- ☐ Other: (Describe)

Provider's Telephone Number

If the service was provided outside the country, include:

Name of Country:

What language is the bill written?

What currency was used for the payment?

National Provider Identification Number

License# and State of License

MEMBER REIMBURSEMENT MEDICAL CLAIM FORM, Continued

If possible, include the itemized bill along with this completed form.

Diagnosis Code	Diagnosis Description	Date(s) of Service	Procedure Code for each service	Procedure Description	Amount Paid
					\$
					\$
					\$
					\$
					\$
					\$
Total Amount Paid					\$

Patient Signature is required

I attest that the above information is true and accurate and that the services were received and paid for in the amount requested as indicated above. I acknowledge that if any information on this form is misleading or fraudulent my coverage may be cancelled and I may be subject to criminal and/or civil penalties for false health care claims.

I understand that reimbursement payment will be made to the Plan subscriber and will contain information about the service (e.g., provider name, date, description of service). I also understand that BMC HealthNet Plan may request any additional information it deems necessary to verify that services were received and payment was made.

Printed Name	Signature	Date
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Please fold and mail this form (Including copies of required documents) to:

BMC HealthNet Plan
Member Services Dept.
529 Main Street, Suite 500
Charlestown, MA 02129

Your member handbook contains a full description of your covered services, coverage exclusions, any certain benefit limitations or conditions and what cost-sharing you must pay for covered services.

If you have any questions on the reimbursement process or would like to check the status, contact Member Services at
MassHealth: 1 (888) 566-0010
QHP/ConnectorCare: 1 (855) 833-8120

Member Services is available Monday through Friday, 8:00 a.m. to 6:00 p.m.

Boston Medical Center HealthNet Plan 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 1-888-566-0010 (TTY: 711).
ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-888-566-0010 (TTY: 711).

MEMBER REIMBURSEMENT MEDICAL CLAIM FORM HELP SHEET

FIELD NAME	DESCRIPTION
Subscriber Information	Subscriber is the person: <ul style="list-style-type: none">Who enrolls in BMC HealthNet Plan and signs the membership application form on behalf of him/herself and any dependents.In whose name the premium is paid.
Patient's BMC HealthNet Plan ID#	The ID number with two digit suffix found on the front of the BMC HealthNet Plan ID card, underneath the member's name.
Patient's Name	Last and first name, middle initial of the patient who received the services.
Patient Date of Birth	Date of birth with 2 digit month, 2 digit day, and 4 digit year. For childbirth class reimbursement: include the date of birth of the newborn or the mother's due date.
Provider's Name, Address, telephone number, License#, and State of License	A provider includes, but is not limited to, hospitals, physicians, optometrists, psychiatrists, licensed clinical social workers, durable medical equipment suppliers and pharmacies.
In what setting did the patient receive treatment?	Such as office, emergency room, outpatient hospital for x-rays, laboratory, inpatient hospital, clinic, medical supply store, etc.
If the services were rendered outside of the U.S.	If applicable, indicate in what country the services were provided, the language (if not English) the bill and proof of payment were 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. (Example: Flu, broken leg, asthma, etc.)
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. (Example: X-ray, Office visit, Leg cast, etc.)
Total Amount Paid	The 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 amount paid.
Proof of Payment	A document that demonstrates the payment made by the member for the services provided by the health care provider or facility. Examples include: <ul style="list-style-type: none">Front and back of the cashed check written to the providerA credit card statement or receiptA statement from the provider on the provider's letterhead with authorized signature indicating payment was madeReceipt for purchased items or services with the provider's name and address pre-printed on the receipt, with items listed and total amount paid.

Important! This material can be requested in an accessible format by calling 1-888-566-0010.

Ważne! Te informacje dotyczą korzyści zapewnianych przez BMC HealthNet Plan. Konieczne jest ich natychmiastowe przetłumaczenie. BMC HealthNet Plan może przetłumaczyć je dla Ciebie. Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer **1-888-566-0010 (TTY: 711)**. (POL)

Importante! Esta informação é sobre os benefícios de seu Plano BMC HealthNet. Ela precisa ser traduzida imediatamente. O Plano BMC HealthNet pode traduzi-la para você. Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para **1-888-566-0010 (TTY: 711)**. (PTB)

Важно! Эта информация касается ваших льгот по плану BMC HealthNet Plan. Ее необходимо перевести незамедлительно. Такую услугу вам может предоставить план BMC HealthNet Plan. Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните **1-888-566-0010 (TTY: 711)**. (RUS)

¡Importante! Esta información es sobre los beneficios de su BMC HealthNet Plan. Necesita traducirse inmediatamente. BMC HealthNet Plan también traducirlo por usted. Si habla Español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-888-566-0012 (TTY: 711)**. (SP)

Lưu ý! Đây là thông tin về phúc lợi BMC HealthNet Plan của bạn. Cần phải dịch ngay. BMC HealthNet Plan có thể dịch nó cho bạn. Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số **1-888-566-0010 (TTY: 711)**. (VIET)

Notice About Nondiscrimination and Accessibility Requirements and Nondiscrimination Statement: Discrimination is Against the Law

Boston Medical Center HealthNet Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Boston Medical Center HealthNet Plan does not exclude people or treat them differently because of race, color national origin, age, disability, or sex. Boston Medical Center HealthNet Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services, contact Boston Medical Center HealthNet Plan.

If you believe that Boston Medical Center HealthNet Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Civil Rights Coordinator
529 Main Street, Suite 500
Charlestown, MA 02129
Phone: 1-888-566-0010 (TTY/TDD 711)
Fax: 1-617-897-0805
Hours: Monday-Friday 8:00 a.m. - 6:00 p.m

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Boston Medical Center HealthNet Plan is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are also available at <http://www.hhs.gov/ocr/office/file/index.html>.