MEMBER REIMBURSEMENT - MEDICAL CLAIM FORM

(**For Medical claims only** - please complete one form per provider, per date of service)

FHCP Medicare

Instructions

1. To request reimbursement, please submit the following to the address listed at the bottom of this form within **12 months** of the date of service. Extensions may be granted based on circumstances. Any missing information may result in delay or denial of the request.
   (a) This completed and signed reimbursement form or a written request for reimbursement with all necessary information, (b) Proof of services rendered, and (c) Proof of payment for the services being rendered.
2. You may need your health care provider to assist and supply information in completing your request, including the procedure code(s) and diagnosis code(s). Refer to FAQs on page two for additional information.
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 payment will be sent to the patient at the address FHCP has on record.
5. Retain a copy of all receipts and documentation for your records.

Patient Information

FHCP ID	Last Name	First Name	Middle Initial
Date of Birth	Telephone Number	Email Address	
Mailing Address			
Does patient have additional insurance? ☐ Yes ☐ No		Did other insurance make a payment? ☐ Yes ☐ No (If yes, include other plan's EOB)	
Other Insurance Name	Other Insurance Phone Number	Other Insurance Policy Number	

Claim Information

Treatment Setting	Practice, Group, or Facility Name	Provider/Group Federal Tax ID	
Service Location / Provider Address			
Provider Name	Provider NPI Number	Telephone Number	Fax Number
If services were received outside of the United States, please provide information regarding country, documentation language, and currency			
Diagnosis Code(s)			
Detailed explanation of illness / injury, including date(s) of injury/illness, and explanation if a non-participating provider was utilized			

Date of Service	Procedure Code	Procedure Description	Amount Paid
		Total Amount Paid	$ 0.00

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 Member and will contain information about the service (e.g., provider name, date, description of service). I also understand that FHCP may request any additional information it deems necessary to process the claim.

Patient (or guardian / representative) Printed Name _____ Signature _____ Date _____

Checklist

- ☐ I have completed and signed this form in its entirety
- ☐ I have enclosed documents for Proof of Services received
- ☐ I have enclosed documents for Payment of Services received

Please submit this form and all documentation to:
FHCP Medical Claims Department – Member Reimbursement
P.O. Box 10348
Daytona Beach, FL 32120-0348
or via Email to Claims@FHCP.com

Member Reimbursement Medical Claim Form FAQs

Question	Answer
What is this form used for?	Member Reimbursement Medical Claim Forms should be submitted in circumstances when you have been required to pay for medical services at the time services were rendered such as urgent/emergent care received from non-contracted, out-of-network, or out-of-area provider(s). *You don't have to use this form, but it will help us process the information faster. If you do not use the form, ensure you submit with your request an itemized bill with the following information: •Date of service •Place of service •Description of illness or injury •Description of each surgical or medical service or supply furnished •Charge for each service •The doctor's or supplier's name and address •The provider or supplier's National Provider Identifier (NPI) If known •If the itemized bill is from a clinical laboratory, an independent diagnostic imaging center, or a DME provider, the ordering & referring providers legal name and National Provider Identifier (NPI) if known MUST be included on the itemized bill.*
What is my responsibility?	Cost share, such as copayments, deductibles, and/or coinsurance, and non-covered services, will be member responsibility. Actual payment for covered service(s)will be paid at the appropriate level according to your plan benefits. Please note that submission for reimbursement does not guarantee payment. Only covered services deemed medically necessary will be considered for reimbursement. Refer to your Evidence of Coverage for limitations, exclusions, and requirements for prior authorization or referral.
What if my service was completed out of the service area?	If you were temporarily out of the service area and had a medical emergency, be sure to report your emergency to us as soon as possible. Copayments, deductibles, coinsurance, and non-covered services will be patient responsibility. Routine care is not covered outside the service area and will not be reimbursed unless you have prior authorization from FHCP and/or services are eligible under the FHCP Medicare Rx Plus POS plan.
Who should I contact if I need help with completing this form?	Contact the Provider of Service for provider related information such as Federal Tax ID or NPI number, or for claim specific information such as diagnosis codes, procedure codes, or procedure descriptions. If you need assistance in completing this form not related to provider or specific claim information, please contact Claims Customer Service at 386-615-5010.

Field Name	Description / Information
FHCP ID	(6) digit Member ID with (3) letter prefix, found on the front of the FHCP ID Card
Treatment Setting	Such as office, emergency room, outpatient hospital (for X-rays, tests), inpatient hospital, clinic, medical supply store
Diagnosis Code(s)	Provide ICD-10 diagnosis code(s) – contact provider to obtain
Detailed explanation of illness/injury	Provide a detailed description of illness or injury (e.g., flu, broken leg, manic-depressive disorder, asthma), including relevant dates / locations, and an explanation if a non-participating provider was utilized.
Procedures, Services, or Supplies Provided	Provide CPT or HCPCS codes for the procedures, services, or supplies provided – contact provider to obtain
Proof of Service(s)	A document that demonstrates the service was actually rendered, listing date(s) of service, service(s) provided, and dollar amounts charged and paid. An industry standard "superbill" will usually contain all the information necessary.
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.