allways[sm]
HEALTH PARTNERS

MEMBER REIMBURSEMENT REQUEST CLAIM FORM

Subscriber's Name _____

Subscriber's Member ID Number_____

Date of Birth _____ Employer's Name _____
(if applicable)

Address _____

City _____ State_____ Zip Code _____

Reimbursement Request Details

Member Name _____

Date of Birth _____ Gender _____ **Requested Amount $**_____

Member's relationship to the Subscriber (please check the applicable box)

- ☐ Self (Subscriber)
- ☐ Child/Dependent
- ☐ Spouse
- ☐ Other (please specify) _____

Does the Member have other insurance? Yes ____ No ____ ***(if Yes, complete the items below)***

Secondary Coverage:	Effective Date	Policy/ID Number
☐ Medicare Part A (Hospital)	_____	_____
☐ Medicare Part B (Medical)	_____	_____
☐ Medicare Part A (Pharmacy)	_____	_____
☐ Other _____	_____	_____

If applicable, please complete the information below for Secondary Coverage insurance

Name _____ Address _____

Treatment Reason **Date**

- ☐ Work Accident _____
- ☐ Other Accident _____
- ☐ Auto Accident _____

Auto Insurance Name (if applicable) _____ *Auto Insurance Policy Number* _____

I authorize the release of medical and/or other information necessary to process this claim.

Subscriber's Signature _____ Date _____

MEMBER REIMBURSEMENT REQUEST CLAIM FORM
Instructions

- Reimbursement request claims must be submitted within 12 months of the date of service.
- Please submit your claim **only after being billed for services** by a Provider that cannot bill AllWays Health Plan directly.
- Submit separate reimbursement requests for each Member.
- Submit any relevant documentation to support your request, including the following
    - Any claim summaries, Explanation of Benefits, etc. that you may have received from Medicare and/or another insurer
    - For prescription drugs reimbursement requests, receipts that at a minimum, reflects the following
        - Drug's name
        - National Drug Code (NDC) number
        - Date filled
        - Dispensed quantity
        - Prescribing Provider's name
    - An original itemized bill on the Provider's letterhead that at a minimum, reflects the required information below:
        - Provider's name and credentials (i.e. MD, DO, etc.)
        - Provider's address
        - National Provider Identifier (NPI)/Tax ID number
        - Member/Patient's name
        - Service date(s)
        - Itemized charges for each date and type of service received
        - Procedure codes (CPT/HCPCS/Revenue Code for services rendered
        - Diagnosis code(s) for services received
        - Number of units (i.e. the number of times a service was performed on a particular date of service)
    - For services rendered outside the United States, please specify the foreign currency's name (i.e. Euros, Pesos, British Pounds, etc.)
- Reimbursement requests are subject to approval by AllWays Health Partners and AllWays Health Partners may contact Providers to validate services rendered and/or other information.
- Please make copies for your records of original receipts and any other documents being submitted with your reimbursement request. AllWays Health Partners cannot return these, even for denied requests.
- Please allow 30 business days for processing.
- **To ensure the timely processing of your reimbursement request, be sure to submit the following items:**
    - This completed form, signed and dated
    - Proof of payment
    - Any other supporting documents

Submit completed form and corresponding attachments to:
AllWays Health Partners
Manager of Claims
399 Revolution Drive – Suite 940
Somerville, MA 02145