allways℠
HEALTH PARTNERS

Medical and Behavioral Health reimbursement

This checklist will guide you through the process of requesting a medical or behavioral health reimbursement.

If your plan includes a fitness or weight loss benefit, please use the e-forms on the member portal under "Track costs and claims" to request a reimbursement.

I have completed or attached the following:

☐ **Signed member reimbursement form with all sections clearly completed. This form is on the next page.**

☐ **For medical and/or behavioral health claims, an itemized provider bill that includes:**

1. Provider information:
   - Provider name
   - Provider address
   - National Provider Identifier and/or Provider Tax Identification Number
2. Patient's name
3. Date(s) of service
4. Itemized charges for each date of service and type of service received
5. Procedure codes (CPT/HCPCS/Revenue codes) for all services received
6. Number of units billed for each procedure code (CPT/HCPCS/Revenue Code)
7. Diagnosis code(s) for services received
8. If the claim is for services received outside of the United States, please include the name of the foreign currency (for example: Euros, Pesos, British Pounds, etc.)

☐ **For prescription drug claims, an itemized pharmacy receipt that includes:**

- National drug code
- Name of drug
- Date dispensed
- Quantity dispensed
- Name of prescribing physician

☐ **Proof of payment:**

- Credit or debit card statement
- Financial statement that includes a copy of the front and back of canceled check issued to the provider
- Receipt of payment by provider for cash payments (all cash payments must include proof of source of funds such as wire transfer, travelers check receipt, or bank statement)

AllWays Health Partners may contact providers to validate services rendered and/or payment amounts.

Most completed reimbursement requests are processed within 30 days. Incomplete requests and requests for services rendered outside of the United States may take longer. AllWays Health Partners will contact providers to validate services rendered and/or payment amounts.

Questions about this form? Call the customer service number on the back of your member ID card, email **customerservice@allwayshealth.org**, or visit **allwaysmember.org** to chat with a customer service professional.

Member Reimbursement Claim Form
for Medical and Behavioral Health Services

allways℠ HEALTH PARTNERS

Is this claim for ☐ Medical or ☐ Behavioral Health services?

1. Complete this form and checklist to request reimbursement when a provider bills you directly for a covered service.
2. Requests must be submitted within 12 months of the date of service.
3. Complete one form per family member and one form per claim.
4. Keep a copy of all receipts and documents for your records.

AllWays Health Partners reserves the right to request further information to support your claims.

A. Patient and Subscriber (Plan Holder) Information

1. Patient Member ID	2. Patient Name FIRST LAST MIDDLE INITIAL	3. Patient Date of Birth MONTH DAY YEAR
4. Patient Address		
5. Relationship to Subscriber ☐ Subscriber ☐ Child ☐ Dependent ☐ Spouse ☐ Other (specify) _____		
6. Subscriber ID Number *if different from patient*	7. Subscriber Name FIRST LAST MIDDLE INITIAL	
8. Employer Name *if group insurance*		9. Subscriber Date of Birth MONTH DATE YEAR
10. Secondary Coverage: Does the Patient have other insurance? ☐ Yes ☐ No Name and ID number of the plan:		11. Was this claim due to an accident? ☐ Yes ☐ No

B. Provider or Hospital Information

12. Provider's Name	13. Contact Person *if available*	14. Provider Phone Number
15. Provider Address	16. Outside the USA In what country was the patient seen? _____ In what language was the bill written? _____ In what currency was the bill paid? _____	

C. Description of Services

17. Type of Service, *please check the type of service that was rendered*

☐ Behavioral health	☐ Inpatient surgery	☐ Lab or x-ray services	☐ Other _____
☐ Office visit	☐ Outpatient surgery	☐ Covered prescription drugs	_____
☐ Inpatient hospital care	☐ Emergency room visit	☐ Medical supplies	_____

18. Please describe what you were seen for/diagnosis. *(e.g., broken limb, sore throat, earache, etc.)*

19.

Date(s) of service	Description of procedures, services, or supplies provided	Amount paid

Please indicate total amount paid for services, *include total in foreign currency and the U.S. equivalent if necessary* _____

20. Did you have a COVID-19 lab test?
If yes, please select only one option below. **Required if you answered yes.**

- ☐ I had possible exposure to COVID-19 or was exposed to someone who has COVID-19.
- ☐ I was tested because I have exhibited symptoms of COVID-19.
- ☐ I was tested, but have not been exposed and have not exhibited symptoms related to COVID-19 (asymptomatic).
- ☐ I was tested for return-to-work purposes.
- ☐ I was tested for return-to-school purposes.
- ☐ I was tested for travel purposes.

Please mail or fax this form and all documentation to:

AllWays Health Partners
Claims Processing
399 Revolution Drive
Suite 810
Somerville, MA 02145

Fax: 617-526-1902

I hereby apply for benefits and certify that the above information is complete, true and correct. To all physicians and other medical professionals, hospitals, and other medical care institutions, and to insurers, medical or hospital service and prepaid health plans, employers and group policy holders, contract holders or benefit plan administrators: You are authorized to provide the Plan and any benefit plan administrators from consumer reporting agencies, attorneys and independent claim administrators acting on the Plan's behalf, with information concerning medical care, advice, treatment or supplies provided to the Patient, and any employment related information regarding the Patient. This information will be used for the purpose of evaluating and administering claims for benefits. I understand that the duration of the authorization is for the term of coverage of the policy or contract under which a claim for health benefits has been submitted. I understand that I have a right to receive a copy of this authorization upon request. I agree that a photographic copy of this authorization is as valid as the original. It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

Form must be signed. Claim cannot be processed without member's signature.

MEMBER'S SIGNATURE DATE SUBSCRIBER'S SIGNATURE DATE