elderplan®

*Leading the way to great care.*

# Member Reimbursement Form

**If you personally paid for a covered medical service, make sure you and your physician, or other health care professional, fill out this form completely in order for you to receive timely reimbursement.**

- Type or print requested information.
- Ask your provider(s) to help you complete all information in Part II.
- Attach itemized receipts or claim forms for each service. (Do not staple items.)
- Please keep a copy of each itemized bill or receipt for your records.
- Do not submit a form if your physician or other health care professional is also filing a claim to Elderplan for the same service.
  - *For reimbursement you must see an in-network provider or facility.*

## PART I — MEMBER INFORMATION

| Last Name | First Name | Middle Initial | Member ID# | DOB (mm/dd/yy) |
|---|---|---|---|---|
| | | | | |

| Street Address | City | State | Zip |
|---|---|---|---|
| | | | |

| Patient Name | Patient DOB (mm/dd/yy) | Phone |
|---|---|---|
| | | |

## PART II — SERVICE INFORMATION (To be filled out by provider)

| Date (mm/dd/yy) | Place of Service | Codes for Procedures, Services or Supplies | Diagnosis Code | Charges | Number of Units |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

| **Total Charges:** | **Amount Paid by You:** |
|---|---|

| Provider Name | Provider Tax ID # |
|---|---|
| | |

| Street Address | City | State | Zip |
|---|---|---|---|
| | | | |

For questions or assistance, please call the number on the back of your ID card. If all information has been correctly submitted, you can expect your claim to be processed within 30 business days of receipt by Elderplan. THIS IS NOT A GUARANTEE OF PAYMENT. Actual payment for covered services will be paid at the appropriate level according to your plan benefit.

*Over*

**Member Attestation**

By signing below, I attest that I have paid the dollar amount listed above for the services received while an Elderplan Medicare Plan member. I further certify that the documents attached to this form demonstrating proof of payment are accurate, true, and complete, in all respects.

Signature Date

*If you are the authorized representative, you must sign above and provide the following information:

Name Phone Relationship to Enrollee

Street Address City State Zip

## Mail to:

Elderplan Claims Department
P.O. Box 73111
Newnan, GA 30271-3111

### Before you submit your claim...

**1.** Be sure that all fields are completed.
**2.** Make photocopies of all receipts and completed forms. Receipts will not be returned.
**3.** Write your Elderplan member ID number on all paperwork you submit.

You will receive your reimbursement within 30 days from when we receive the form. Please keep a copy of all paperwork for your records.

If you have any questions, please contact **Member Services** at **1-800-353-3765** (TTY 711) from 8:00a.m. to 8:00p.m., seven days a week.

Elderplan/Homefirst complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Elderplan/Homefirst cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-353-3765 (TTY: 711).

Elderplan/Homefirst遵守適用的聯邦民權法律規定，不因種族、膚色、民族血統、年齡、殘障或性別而歧視任何人。

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-353-3765 TTY 711 。

elderplan|homefirst®
a member of MJHS Health System