Minuteman Health

MEMBER REIMBURSEMENT MEDICAL CLAIM FORM

(One per patient per provider)

Read instructions on the back before completing & signing this form.

Please print clearly, complete all sections and sign. Retain a copy of all receipts and documents for your records.

MEMBER INFORMATION

MEMBER NAME (Last, First, Middle Initial)		MEMBER MINUTEMAN HEALTH ID #	
STREET ADDRESS	APT #	PO BOX	PHONE
CITY		STATE	ZIP

MEMBER'S RELATIONSHIP TO SUBSCRIBER (Circle One)

SELF SPOUSE CHILD OTHER, *PLEASE SPECIFY* ____________________

DOES THE MEMBER HAVE ANY OTHER INSURANCE? YES ☐ NO ☐
IF YES,
MEMBER ID #________________________________
NAME & ADDRESS OF OTHER INSURANCE:

WAS TREATMENT FOR :
ACCIDENT AT WORK? YES ☐ NO ☐ DATE OF ACCIDENT: ____/____/______
AUTO ACCIDENT? YES ☐ NO ☐ DATE OF ACCIDENT: ____/____/______
OTHER ACCIDENT? YES ☐ NO ☐ DATE OF ACCIDENT: ____/____/______

DIAGNOSIS: WHAT WERE YOU SEEN FOR?
DIAGNOSIS CODE ____________ DESCRIPTION: ______________________
DIAGNOSIS CODE ____________ DESCRIPTION: ______________________
DIAGNOSIS CODE ____________ DESCRIPTION: ______________________

DATE(S) OF SERVICE	PROCEDURE CODE AND DESCRIPTION OF PROCEDURE, SERVICES OR SUPPLIES	AMOUNT PAID

REQUIRED INFORMATION *(The following information must be provided when you submit this form).*

PROOF OF SERVICE:

☐ An itemized bill from the provider of service, listing dates of service, services provided and amount paid.

PROOF OF PAYMENT *THROUGH ONE OF THE FOLLOWING:

☐ Front and back of a cancelled check written to the provider or the bank encoded front of the check OR a credit card statement OR a credit card or cash register receipt.

*Itemized statements and/or invoices do not count as proof of payment

I understand that Minuteman Health will only reimburse me for services covered by my health plan.
I authorize the release of any medical or other information necessary to process this claim. I attest that the above information is true and accurate, and that 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 healthcare claims.

(X)

MEMBER'S OR OTHER AUTHORIZED PERSON'S SIGNATURE DATE

Please submit this form and all documentation to:
Minuteman Health – Member Reimbursements
One Monarch Place, Suite 1500
Springfield, MA 01144-1500

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Minuteman Health

One Monarch Place • Suite 1500
Springfield, MA 01144-1500
minutemanhealth.org

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INSTRUCTIONS

Requests for reimbursement must be received at Minuteman Health within six months of the date of service. If all applicable information is not submitted, your request for reimbursement will be denied. We strongly advise that you check your Summary Plan Description or Explanation of Benefits. You will NOT be reimbursed for services on items not covered by your plan. Any applicable deductible, coinsurance, or copayment will be applied.

Please allow 4 – 6 weeks for processing.

The following information is required:

1. An Itemized bill must be preprinted with the provider's name and address and phone number. This itemized bill MUST also include the following information:

   A. Provider Tax ID/NPI
   B. Provider credentials (initials associated with the educational degrees the provider has earned. (Examples include: MD, LICSW, DC, PT, OT, ST)

2. Member's name

3. Date(s) of service

4. Itemized charges for each date of service and type of service received

5. CPT, HCPCS, or revenue codes for all services received

6. Diagnosis code(s) for services received

7. Number of units - this is the number of times a service was performed on a particular date of service. This is required for occupational, physical and speech therapies and chiropractic services. For anesthesia the total minutes are required.

8. Attach any relevant claims summaries or Explanation of Medicare Benefit forms you may have received for these services, including those received from other insurance companies.

9. If services were rendered outside the United States, please provide an itemized bill, translated into English, which shows the amount paid in U.S. dollars.

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