Medicare Advantage Claim Reimbursement Form

This form is used for members who have paid out of pocket and are requesting reimbursement. You must submit your claim to us within 365 days of the date you received medical services.

Instructions:

1. **Complete this form and attach your bill, receipts and any other documentation related to this reimbursement request. Forms without the required information may delay the processing of your request.**

   IMPORTANT: This information must be on the bill or invoice you submit as it is required to process the claim. Missing information can result in a delay or non-payment of the claim.

   - Name and address of provider (doctor, hospital, laboratory, ambulance service, Tax ID, etc.)
   - Name of patient
   - Procedure Codes
   - Date of service
   - Amount charged for each service
   - Diagnosis code

   If you do not have a document with this information, ask your provider to give you a bill or invoice that includes all of the above for each date of service.

2. **Once you have completed the form, mail it to:**

   Bright Health Medicare Advantage-Claims
   PO Box 853960
   Richardson, TX 75085-3960

   Be sure to attach the invoice or bill and any receipts of your payments.

What happens next:

- It can take up to 60 days to process the claim submission
- After we process your claim, we will send you and Explanation of Payment (EOP) with a check for applicable reimbursement based on your plan benefits.

For questions, call 855-521-9342.

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Member Claim Form

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Please use a separate claim form for each patient. Your cooperation in completing all items on the claim form and attaching all required documentation will help expedite quick and accurate processing. SEE REVERSE SIDE FOR COMPLETE INSTRUCTIONS.

Section A. PATIENT INFORMATION

Last name	First name	M.I.

Does the patient have other health insurance coverage?	Relation to subscriber	Sex	Date of birth (MM/DD/YYYY)
☐ Yes ☐ No	☐ Self ☐ Spouse ☐ Son ☐ Daughter	☐ M ☐ F	

Name of other health insurance company	Group no.	Employer name	Policy no.

Section B. SUBSCRIBER INFORMATION (on Bright Health ID Card)

Identification no.	Group no.

Last name	First name	M.I.

Street address (please include apt. no.)

City	State	ZIP code

Home phone no.	Work phone no.	Date of birth (MM/DD/YYYY)
( ) `	( )	

Section C. MEDICAL INFORMATION

HEALTH CARE SERVICES: Use this section to report any COVERED health service that has not already been reported to this Bright Health Plan by the provider of service (the physician, clinical, ambulance company, private duty nurse, etc.) Attach itemized bill or photocopy. Please be sure that duplicate bills are not submitted.

Was this medical expense the result of an accident? ..... ☐ Yes ☐ No
Was this condition or injury job related? ..... ☐ Yes ☐ No
Have you filed for Workers' Compensation? ..... ☐ Yes ☐ No
When did this injury or accident occur? (MM/DD/YYYY) ___/___/_____

Diagnosis code	Date of Service	Procedure code	Amount Charged

BILLS MUST BE ITEMIZED

Cancelled checks, cash register receipts and non-itemized "balance due" statements cannot be processed. Each itemized bill must include:

- Name and address of provider (doctor, hospital, laboratory, ambulance service, Tax ID, etc.)
- Name of patient
- Procedure code
- Date of service
- Amount charged for each service
- Diagnosis code

I certify that, to the best of my knowledge, the information on this Member Claim Form is true and correct. I authorize the release of any medical information necessary to process this claim.

Signature	Name	Date
X		

HOW TO USE THIS FORM

Most health care providers will submit bills to Bright Health on you or your dependent's behalf. However, if a physician does not bill us they may bill you directly. If you receive a bill from your a health care provider you may use this claim form to submit the charges to Bright Health.

Please read the following instructions for submitting the claim to report the claim to Bright Health.

SECTION A. PATIENT INFORMATION

Use this section to identify the patient.

SECTION B. SUBSCRIBER INFORMATION (on Bright Health ID card)

Use this section to identify the subscriber. Some of this information may be found on your Bright Health card.

SECTION C. MEDICAL INFORMATION: This section pertains to the employee through whose employer your program is obtained

Health Care Services: Use this section to report that has not already been reported to Bright Health. Attach a photocopy of an itemized bill.

MEMBER CLAIM FORM INSTRUCTIONS:

Please mail this claim form and a photocopy of your itemized bill to:

Bright Health
Medicare Advantage-Claims
PO Box 853960
Richardson, TX 75085-3960