# Beneficiary Request for Medical Reimbursement

| A. Beneficiary Information | |
|---|---|
| *Beneficiary Name: | |
| *Beneficiary Date of Birth: | *Beneficiary ID Number: |
| *Sponsor Name: | *Group Name: |

| B. Service Information | |
|---|---|
| *Name of health care provider (physician, facility, pharmacy, etc.): | |
| *Date(s) of service: | *Amount paid for service: |
| *List the illness/injury(s) requiring treatment: | |
| *Was the illness or injury due to an accident? | If yes, date of accident: |
| *Did accident require hospitalization? | If yes, hospital name and address: |
| *Was this a work-related injury/illness? | If yes, name and address of employer: |

| C. Other Health Insurance | |
|---|---|
| *Do you have other health insurance coverage? If yes, provide information below: | |
| Insurance Name and address: | |
| Subscriber Name and address: | |
| Subscriber ID number: | Group Number: |

Please sign and date below. If signature is not provided, this claim will be denied as unable to process.

**Print Name:**_____

**Signature:**_____ **Date:**_____

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**Denotes required field. Determination may be delayed if these fields are not filled out.

## *PATIENT REQUEST FOR MEDICAL REIMBURSEMENT*

In most cases, the provider should bill US Family Health Plan at the address shown on the back of the Beneficiary ID card. However, some out-of-network providers may require immediate payment.

To obtain reimbursement for **covered out-of- network** services as described above, we ask that the request be sent with this form and the required documentation, as soon as possible, after you receive care. However, this form and the required documentation **must** be submitted**,** to the address indicated below within **365 days of the date of service.** Requests submitted after 365 days will be **denied**.

Claims will be reimbursed for covered services at the TRICARE® allowable charge minus beneficiary cost share or billed charges, whichever is lesser. The Point of Service (POS) benefit applies to covered out-of-pocket services received by an out-of-network provider. NOTE: The POS benefit has a higher out-of-pocket cost for covered services than if you had chosen an in-network provider. (50% of total cost applies after the POS deductible is met for formulary and non-formulary covered drugs) Additionally, the provider has the legal right to charge up to 15% more than the TRICARE allowable charge. Any charges above the allowable charge are your responsibility and will not. be reimbursed by US Family Health Plan.

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### SUBMISSION ADDRESS FOR REIMBURSEMENT

Submit this completed form and the required documentation within **365 days of the date of service,** at the address indicated below:

**US Family Health Plan**
Attn: Claims Department
5101 N. O'Connor Blvd.
Irving, TX 75039

### *INSTRUCTIONS TO FILL OUT REIMBURSMENT FORM*

Completed the reimbursement request form as directed below:

1. **Complete Section A:**
   Print the name of the Beneficiary Number as printed on the US Family Health Plan membership ID card.
2. **Complete Section B:**
   Print the name of the of the physician, facility, pharmacy, or other health care professional from whom services were received, the date of the service, and the amount paid. Provide as much information as possible.
3. **Complete Section C:**
   If applicable, print the name and address of your other health insurance, as well as the additional requested information for the subscriber/member policy. If you are submitting multiple requests for reimbursement, this section can be filled out only one time unless there is change that needs to be noted.
4. **Attach Evidence of Payment:**
   Attach copy of original receipt or cancelled check **and** a copy of the bill.
5. **Attach Itemized Statement:** The itemized statement must include the following:
   a) *Procedure (CPT/HCPC) codes for services rendered.*
   b) *Diagnosis (DX) codes for services rendered.*
   c) *Dates of service*
   d) *Provider tax identification number (TIN/EIN), National Provider Identifier (NPI), Provider Name & Address*
   e) *Billed amount for each service.*

***Important Note: If this form and required documents are not included the claim will be denied due to lack of documentation.*** It could take up to 30 days for your request to be uploaded and processed into USFHP systems. (Upload could take even longer if additional research is required for your submission.) Appeals should not be submitted until you receive a determination letter for this service from the plan.

***If you have additional questions regarding your benefits, please contact the US FAMILY Health Plan Member Services department at the number on the back of your member ID card or review the beneficiary handbook, which can be accessed online at christushealthplan.org.***