MEMBER REIMBURSEMENT MEDICAL CLAIM FORM

(**For Medical claims only** - please complete one form per family member per provider)

ambetter of North Carolina Inc.

Instructions

1.You will need your health care provider to assist and supply information in completing this form, including the procedure code(s) and diagnosis code(s). It is recommended that you bring it with you to your appointment. Please also refer to the Help Sheet for additional information.
2. To request reimbursement, please submit the following to the address listed at the bottom of this form (any missing information may result in delay or denial of the request):
a. This completed and signed reimbursement form b. Proof of services rendered c. Proof of payment for the services being requested for reimbursement
3. Most completed reimbursement requests are processed within 45 days. Incomplete requests and requests for services that were rendered outside of the United States may take longer.
4. Reimbursement will be sent to the Plan subscriber (see Help Sheet for definition) at the address Ambetter of North Carolina Inc. has on record (To view your address of record, please log on to AmbetterofNorthCarolina.com or call Member Services at 1-833-863-1310 (Relay 711).
5. Retain a copy of all receipts and documentation for your records.

Subscriber Information

Last Name:	First Name:	Middle Initial:

Patient information

Patient's Ambetter Member ID#:	Last Name:	First Name:	Middle Initial:

Date of Birth (MM/DD/YYYY):	Mailing Address:

Telephone Number:	Patient Email Address:	Does Patient have additional insurance? ☐Yes ☐No	Did other Insurance make a payment: ☐Yes ☐No **(If yes, include plan's EOB)**

Other Insurance Company Name:	Other Insurance Company Phone Number:	Other Insurance Policy Number:

Claim Information

(This section must be completed and you will need your health care provider to assist in completing this section.)

Healthcare Provider's Name:	Setting where treatment was received:	Telephone Number:	Provider Federal Tax ID #:

Healthcare Provider's Address:	Were services received outside of the U.S.? ☐Yes ☐No

Detailed explanation of illness/injury, including date(s) of injury/illness:

Diagnosis Codes	Diagnosis Description (e.g., flu, broken leg, manic-depressive	Date(s) of Service	Procedure Codes (for each service provided)	Procedure Descriptions (e.g., x-ray, office visit, lab work, leg cast, etc.)	Amount Paid
.		/ /			$
.		/ /			$
.		/ /			$
.		/ /			$
Ambetter Member signature is required				**Total Amount Paid**	$

Ambetter of North Carolina Inc. complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Ambetter of North Carolina Inc. does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

I attest that the above information is true and accurate and that the 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 health care claims. I understand that reimbursement payment will be made to the Plan subscriber and will contain information about the service (e.g., provider name, date, description of service).
I also understand that Ambetter of North Carolina Inc. may request any additional information it deems necessary to verify that services were received and payment was made.

Printed Name _____ Signature _____ Date _____

Checklist

1. I have completed and signed this form in its entirety.
2. I have enclosed documents of Proof of Services received (see the help sheet for an example of proof of payment).
3. I have enclosed documents of Payment of Services – not related to copay or plan deductible (see the help sheet for an example of proof of payment).
4. I understand that most completed reimbursement requests are processed within 45 days. Incomplete requests and requests for services rendered outside of the United States may take longer.

Please submit this form and all documentation to:

Ambetter of North Carolina Inc. • Claims Department-Member Reimbursement • P.O. Box 5010 • Farmington, MO 63640-5010

MEMBER REIMBURSEMENT MEDICAL CLAIM FORM - HELP SHEET / FAQs

Question	Answer
What is this form used for?	This form is used to ask for payment for eligible Medical care you have already received. This form should not be used for Vision, Dental or Pharmacy services.
What is my responsibility?	Copayments, deductibles, coinsurance, and non-covered services will be patient responsibility.
What if my service was completed out of the service area?	If you were temporarily out of the service area and had a medical or behavioral health emergency, be sure to report your emergency to us within one (1) business day. Depending on your plan type, copayments may apply for emergency care received in an emergency room. Routine or maintenance care is not covered outside the service area and will not be reimbursed unless pre-arranged with Ambetter prior to receiving services.
What happens next?	After processing your claims, you will receive an Explanations of Benefits (EOB). The EOB explains the charges applied to your deductible (the fixed dollar amount you pay for covered services before the insurer starts to make payments) and any charges you may owe the provider. Please keep your EOB on file in case you need it in the future. You may also refer to your member handbook on AmbetterofNorthCarolina.com.
Did you know?	You receive a higher benefit if you use an Ambetter of North Carolina Inc. provider. This can be especially cost effective when receiving ongoing services like therapy services or when purchasing durable medical equipment.
Who should I contact if I need help with completing this form?	Contact Member Services at 1-833-863-1310 (Relay 711)
Field Name	**Description**
Subscriber Information	Subscriber is the person: Who enrolls in an Ambetter of North Carolina Inc. and signs the membership application form on behalf of him/ herself and any dependents. In whose name the premium is paid.
Patient's Ambetter Member ID#	ID# with suffix, found on the front of the Ambetter of North Carolina Inc. Member ID card.
Patient's Name	Last and First names and Middle Initial of patient who received services.
Patient's Date of Birth	Date of birth: month (2 digits), day (2 digits), year (4 digits). Include newborn's date of birth in the same box as the parent(s).
Provider's Name, Address, Telephone Number, Provider Federal Tax ID #:	A provider includes, but is not limited to, hospitals, physicians, optometrists, psychiatrists, licensed clinical social workers, durable medical equipment suppliers.
In what setting did the patient receive treatment?	Such as office, emergency room, outpatient hospital (for X-rays, tests), inpatient hospital, clinic, medical supply store.
If services were rendered outside of the U.S.	If applicable, indicate in what country services were provided, in what language (if not English) the bill and proof of payment were written, and in what currency the bill was paid.
Diagnosis: What was the patient seen for?	Provide a diagnosis code and detailed description of illness or injury. (e.g., flu, broken leg, manic-depressive disorder, asthma)
Date(s) of Service	The date(s) the services were provided to the patient.
Procedures, Services, or Supplies Provided	Provide a procedure code and detailed description. (e.g., x-ray, office visit, lab work, leg cast, etc.)
Total Amount Paid	Total amount for which you are requesting reimbursement.
Proof of Service(s)	A document that demonstrates the service was actually rendered, listing date(s) of service, service(s) provided, and dollar amounts paid.
Proof of Payment	A document that demonstrates payment made by the member was received by the provider of service. Examples include: The front and back of the cancelled check written to the provider or the bank encoded front of the check written to the provider; a credit card statement or receipt; a statement from the provider, on the provider's letterhead with authorized signature, indicating payment was made; a receipt for purchased items, with the provider's name and address preprinted on the receipt, with items listed and amount paid.

Please submit this form and all documentation to:
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