Member Reimbursement Form

MassHealth, NH Medicaid and Clarity plans

Instructions: Please complete one form per family, per provider

1. You will need your health care provider to assist and supply information in order to complete this form. It is recommended that you bring this form with you to your consultation visit. Please also refer to the Help Sheet for additional information.
2. Please submit the completed Reimbursement Medical Claim Form along with the additional documents and receipts to WellSense Health Plan as soon as possible. The following documents are required.
   a. Member Reimbursement Medical Claim Form (Completed and signed)
   b. Proof of services rendered (Itemized bill or invoice)
   c. Proof of payment for the services being requested for reimbursement (Receipt, bank statement, invoice with payment details. For childbirth classes, include a certificate of completion.)
3. The reimbursement review process takes approximately 4 to 6 weeks to complete.
4. Reimbursement will be sent by mail to the WellSense subscriber at the address WellSense Health Plan has on record.
5. Keep a copy of all receipts and documents for your own records.
6. **Timely Filing Limit:** Submit the form with receipts:
   a. within 6 months from the date of service for Clarity plans and QHP.
   b. within 365 days from the date of service for NH Medicaid.
   c. at any time for MassHealth members, there is no filing limit.

Subscriber Information		
Subscriber last name	First name	Middle initial

Patient information (please print information clearly)

Member ID Number (Found on your WellSense ID card)		
Member's Last Name		
First Name		Middle initial
Date of birth (MM/DD/YYYY)	Telephone number	Email address

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Claim information (This section must be completed. Your health care provider can assist in completing this section.)

Health care provider's name and address	Setting where treatment was received: ☐ Outside the U.S. (describe in box below) ☐ Hospital/Urgent Care outside the service area ☐ Hospital/Urgent Care inside the service area ☐ Doctor's office ☐ Laboratory/High imaging ☐ Other: (Describe)
Provider's telephone number	If the service was provided outside the country, include: Name of Country: What language is the bill written? What currency was used for the payment?
National Provider Identification Number	License# and State of License

If possible, include the itemized bill along with this completed form.

Diagnosis Code	Diagnosis Description	Date(s) of Service	Procedure Code for each service	Procedure Description	Amount Paid
					$
					$
					$
					$
				Total Amount Paid	$

Patient Signature Required

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 WellSense subscriber and will contain information about the service (e.g., provider name, date, description of service). I also understand that

WellSense Health Plan may request any additional information necessary to verify that services were received and payment was made.

Printed name	Signature	Date

Please fold and mail this form (including copies of required documents) to:

WellSense Health Plan
ATTN: Member Services
100 City Square, Suite 200
Charlestown, MA 02129

Your member handbook contains a full description of your covered services, coverage exclusions, any certain benefit limitations or conditions and what cost-sharing you must pay for covered services.

If you have any questions on the reimbursement process or would like to check the status, contact Member Services at:

MassHealth:	888-566-0010
Clarity plans/QHP:	855-833-8120
NH Medicaid:	877-957-1300

Member Services is available Monday through Friday, 8:00 a.m. to 6:00 p.m.

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

ATENCIÓN: Si habla Español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 888-566-0010 (TTY: 711).

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 888-566-0010 (TTY: 711).

Member Reimbursement Medical Claim Form Help Sheet

Field Name	Description Name
Subscriber information	Subscriber is the person: • Who enrolls in WellSense Health Plan and signs the membership application form on behalf of him/herself and any dependents. • In whose name the premium is paid.
Patient's WellSense Health Plan ID#	The ID number with two digit suffix found on the front of the WellSense Health Plan ID card, underneath the member's name.
Patient's Name	Last and first name, middle initial of the patient who received the services.
Patient Date of Birth	Date of birth with 2 digit month, 2 digit day, and 4 digit year. For childbirth class reimbursement: include the date of birth of the newborn or the mother's due date.
Provider's Name, Address, telephone number, License# and State of License	A provider includes, but is not limited to, hospitals, physicians, optometrists, psychiatrists, licensed clinical social workers, durable medical equipment suppliers and pharmacies.
In what setting did the patient receive treatment?	Such as office, emergency room, outpatient hospital for x-rays, laboratory, inpatient hospital, clinic, medical supply store, etc.
If the services were rendered outside of the U.S.	If applicable, indicate in what country the services were provided, the language (if not English) the bill and proof of payment were written, and in what currency the bill was paid.

Field Name	Description Name
Diagnosis: What was the patient seen for?	Provide a diagnosis code and detailed description of illness or injury. (Example: Flu, broken leg, asthma, etc.)
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. (Example: X-ray, Office visit, Leg cast, etc.)
Total Amount Paid	The 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 amount paid.
Proof of Payment	A document that demonstrates the service was actually rendered, listing date(s) of service, service(s) provided, and dollar amount paid. Examples include: • Front and back of the cashed 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 • Receipt for purchased items or services with the provider's name and address pre-printed on the receipt, with items listed and total amount paid.