



3100 Easton Square Place  
Suite 300  
Columbus OH 43219  
Phone: 800-240-3851  
Fax: 833-256-2871

## Direct Member Reimbursement Form

Please submit the completed form to Trinity Health Plan New York at the address listed above. A complete description of reimbursement coverage is provided in your Evidence of Coverage.

**Don't forget to include:**

- Your itemized bill       A copy of your paid receipt       A copy of the prescription for your eyeglasses (if applicable)

By submitting this claim form, you are requesting reimbursement from Trinity Health Plan New York. I certify that I have incurred these expenses and have proof of payment.

### Membership Information

<b>First Name</b>	<b>Last Name</b>	<b>Middle Initial</b>
<b>Member ID</b>	<b>Date of Birth</b> / /	<b>Phone Number</b> ( )
<b>Sex</b> <input type="checkbox"/> Male <input type="checkbox"/> Female		

Please carefully read and complete the following information before signing and dating this reimbursement form:

- I understand that my signature (or the signature of the person legally authorized to act on my behalf) on this application means that I have read and understand the contents of this application. If signed by an authorized representative (as described above), this signature certifies that:
  - This person is authorized under State law to complete this enrollment, and
  - Documentation of this authority is available upon request by Medicare.

<b>Your Signature</b>	<b>Date</b> / /
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**Attention Provider: Please assist our Trinity Health Plan New York member in the completion of provider certification/verification and the description of services.**

**Provider Certification/Verification**

<b>Provider First Name</b>		<b>Last Name</b>	
<b>Provider NPI</b>		<b>Provider TIN</b>	
<b>Street Address</b>			<b>City</b>
<b>State</b>	<b>ZIP</b>	<b>County</b>	

**Participating Medicare provider?**  Yes  No

**Cataract Surgery?**  Yes - Cataract extraction date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  No

**Diagnosis**

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**Description of Services**

Date of Service	Place of Service	HCPCS Procedure Code	Description of Services	ICD-10	Units	Billed Amount
						\$
						\$
						\$
						\$
						\$

**Amount Paid by Trinity Health Plan New York Member \$** \_\_\_\_\_

For transplant related services, please complete this form for consideration of reimbursement.

In this section, please list your lodging expenses by date for the member and **applicable companion or caregiver**.

Please note that the receipt for lodging items documented below must be included with this form. **Items not eligible for reimbursement are listed on page 4.**

**Lodging Receipts**

Reimbursement based on receipts for sleeping accommodations for those listed below, including tax and tip.

Dates	Name of Hotel or Motel	Number of People	Total Dollar Amount for Reimbursable Lodging

**Mileage**

Please include addresses from the patient’s home to the transplant facility. (Mileage is reimbursed at most current medical mileage rate at [www.IRS.gov](http://www.IRS.gov) and based on MapQuest results.) Gasoline receipts are not required.

Member Home Address	Transplant Facility Address
Date(s) Traveled from Home to Facility	Date(s) traveled from Facility to Home

**Parking Fees**

Date(s)	Parking Fees (Hotel/Motel or Transplant Facility Specific if applicable)

**Miscellaneous**

Please list miscellaneous services or expenses not already addressed in the above sections.

**Please note:** Reimbursement is considered for member and caregiver and based according to Trinity Health Plan New York member benefits.

Date(s)	Name of Service or Expense (e.g., airline ticket)	Total Dollar Amount of Service or Expense

**The following services, including and not limited to are excluded as part of this benefit:**

- Food and alcohol
- Car rental
- Clothing
- Entertainment
- Expenses for persons other than the member’s companion or caregiver
- Non-legible receipts
- Parking fees incurred other than at hotel/motel or hospital
- Personal hygiene items
- Valet
- Any service that is an additional charge to the room charge
- Any mileage that is not to or from the transplant facility
- Any other service not listed in this policy is excluded from reimbursement

Trinity Health Plan New York (HMO) is a Medicare Advantage organization with a Medicare contract. Enrollment in the plan depends on contract renewal. Benefits vary by county. Trinity Health Plan New York complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sexual orientation, sex (defined as sex at birth, legal sex and/or sex stereotyping), and gender (includes gender identity, gender expression and/or pregnancy). ATENCIÓN: is habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-240-3851 (TTY: 711). 注意: 如果您使用繁體中文, 您可以免費獲得語言援助服務。請致電 1-800-240-3851 (TTY: 711).