MERCYONE℠

Health Plan

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 MercyOne Health Plan 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 MercyOne Health Plan. I certify that I have incurred these expenses and have proof of payment.

Membership Information

First Name	Last Name	Middle Initial

Member ID	Date of Birth	Phone Number
	/ /	( )

Sex
☐ **Male** ☐ **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:
    1. This person is authorized under State law to complete this enrollment, and
    2. Documentation of this authority is available upon request by Medicare.

Your Signature	Date
	/ /

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Attention Provider: Please assist our MercyOne Health Plan member in the completion of provider certification/verification and the description of services.

Provider Certification/Verification

Provider First Name | **Last Name**

Provider NPI | **Provider TIN**

Street Address | **City**

State | **ZIP** | **County**

Participating Medicare provider? ☐ Yes ☐ No

Cataract Surgery? ☐ Yes - Cataract extraction date:_____ /_____ /_____ ☐ No

Diagnosis

Description of Services

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

Amount Paid by MercyOne Health Plan Member $ _____

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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 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**

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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 MercyOne Health Plan 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