Member Medical Reimbursement Form

Please print

A. Member Information SEE INSTRUCTIONS SHEET ON HOW TO COMPLETE THIS CLAIM FORM

Member ID Number	**Group No**. (*Employer Group Members only*)	**Telephone No:** (_____) _____ - _____ Area Code
Last Name	**First**	**MI**
Street Address:		
City:	**State/ Zip Code:**	**Date of Birth:** _____ _____ _____ MM DD YYYY

B. Physician Information: Complete this section about the treating provider.

Provider Name:	**Telephone**: (_____) _____ - _____ Area Code
Street Address:	

City:	**State**	**Zip Code:**

C. Claim Information: Complete this section to assist us in processing the claim. Please ask your provider for the diagnosis/code and procedure code information if it is not listed on your bill/receipt.

Date of Service	Diagnosis Code and/or Reason for incurring out-of-pocket expenses	Procedure Code	Charged Amt	Paid Amt
Claim #1 Date of Service:				
Claim #2 Date of Service:				
Claim #3 Date of Service:				

Acknowledgement:

I certify that the information furnished in conjunction with this claim is true and correct. I know it is a crime to fill out this form with facts I know are false. I understand that submission of a claim is not a guarantee of payment of the full amount. If the services are deemed covered services then the health plan will reimburse me their cost share minus any applicable deductible, coinsurance, copayments and/or out-of-network member cost sharing. I understand that the provider will not be paid for this/these service(s).

_____ _____

Member/Authorized Representative Signature Date

"Authorized Representatives must complete an Authorized Representative form and submit it with this claim form or have one on record with the health plan"

Coventry Health Care is a Coordinated Care plan with a Medicare contract and contracts with the Florida, Missouri and Pennsylvania Medicaid programs. Enrollment in our plan depends on contract renewal.

HOW TO COMPLETE THIS MEDICAL CLAIM FORM

1. The Member or Authorized Person must complete the following sections of the Benefit Claim Form:

- Member Information, Physician Information, and Claim Information sections
- Signature of the Member or Authorized Representative. **The form must be signed to process**.
- Proof of Payment that shows your name must be attached, i.e., Doctor's Receipt, Credit Card Receipt, Cancelled Check (front and back), etc.

Note: Please be sure to include all of the required information for your request to be processed without delay.

In addition:

- If you are submitting claims for different providers you **must complete a separate claim form for each provider you paid.**
- If more than three claims are being submitted you may copy this blank form and complete a second form with the additional claims information.
- Keep a copy of this form and your receipts.

2. When to Submit the claim form:

Medical claims must be submitted within 365 days of the date of service. Failure to submit the medical claims within the 365 days would require you to submit a written appeal to your health plan showing good cause for the delay in filing the claim. Please contact Customer Service at the number listed on the back of your ID card if you have any questions about completion of this form or if you wish to file an appeal. Appeals instructions are included in your Evidence of Coverage.

3. Situations in which you should ask the plan to pay our share of the cost of your covered services:

This form should be used in certain instances, for example:

- If you are required to pay the full cost right away from a participating provider.
- If you believe you have paid more than you expected under the coverage of rules of the plan.
- If you received emergency or urgently needed medical care from a non-participating provider.

4. Payment of Claims

When we receive your request for payment, we will let you know if we need additional information from you. We will consider your request and decide whether to pay it and how much we owe. If the services are approved we will pay you for our share of the cost minus any applicable deductible, coinsurance, copayments and/or out-of-network member cost sharing. If we decide that the medical care is not covered, or you did not follow all of the plan rules, we will not pay for our share of the cost. You will receive a written explanation of benefit(s) with the reason(s) for the denied payment and your rights to appeal that decision, as explained above.

5. Submission of the Completed Claim Form:

Return the completed form and applicable receipt(s) to the address for your health plan listed below:

Altius Advantra	**PO Box 7147, London, KY 40742**
Coventry Health Care (AR, KS, OK, Western MO)	**PO Box 7370, London, KY 40742**
Coventry Health Care of Florida	**PO Box 7808, London, KY 40742**
Coventry Health Care of Georgia	**PO Box 7156, London, KY 40742**
Coventry Health Care of Illinois	**PO Box 7141, London, KY 40742**
Coventry Health Care of Iowa/Nebraska	**PO Box 7152, London, KY 40742**
Coventry Health Care of Louisiana	**PO Box 7819, London, KY 40742**
Coventry Health Care of Missouri	**PO Box 8052, London, KY 40742**
Coventry Health Care (North Carolina)	**PO Box 7102, London, KY 40742**
Coventry Health Care (Texas)	**PO Box 7154, London, KY 40742**
(Central/Western PA/Ohio)	**PO Box 7087, London, KY 40742**
Coventry Health Care of West Virginia	**PO Box 7822, London, KY 40742**

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