

# Member Reimbursement Form

Did you know that you can submit your claims reimbursement request online? Just log in to My Plan at HealthPlansInc.com.

Employer Name: \_\_\_\_\_ Group Number: \_\_\_\_\_

### INSTRUCTIONS

Please complete the information below and attach any documentation (receipts, bills, etc.) describing the services that you or your covered dependent has received. Be sure to include the provider's name and full address, the date(s) of service(s), a description of the service(s), the full amount of the charges, and the amount, if any, that you have already paid. Claims for different plan members must be on separate forms.

- Please tape your receipts to the back of this form, or to an additional sheet if necessary.
- Please do not use staples or paperclips, as these may cause a delay in processing.

PLEASE PRINT OR TYPE WHEN COMPLETING THIS FORM

Employee Information					
Employee Last Name		First Name		MI	Health Plans Member ID#
Mailing Address			City	ST	ZIP Code
Date of Birth	Email Address			Primary Phone	

Member/Dependent Information					
			<input type="checkbox"/> Employee	<input type="checkbox"/> Spouse/Partner	
Reimbursement is requested for the following participant (please check):			<input type="checkbox"/> Child/Other Dependent	<input type="checkbox"/> Ex-Spouse	
If reimbursement is requested for a participant <i>other than the employee</i> , please provide the dependent information below:					
Last Name	First Name	MI	Gender	Date of Birth	Relationship

Provider Information					
Please provide the following information:					
Provider's Name	Provider's Address	City	ST	ZIP Code	Provider's Phone#

Services/Products Received			
Please provide the following information:			
DATE(S) OF SERVICE: From: MM/DD/YYYY To: MM/DD/YYYY	DESCRIPTION OF SERVICE(S)/PRODUCT(S)	\$ AMOUNT CLAIMED	HAVE YOU PAID THIS CHARGE?
-			
-			
-			
-			

Assignment of Benefits & Authorization	
Please indicate whether payment should be issued to the plan subscriber, or to the provider listed above:	
<input type="checkbox"/> <b>Issue Payment to the Plan Subscriber</b> <i>I have paid this bill; please reimburse me directly. I have included proof of payment with this claim.</i>	<input type="checkbox"/> <b>Issue Payment to the Provider Named Above</b> <i>I have not paid this bill; please issue payment to the provider named above.</i>
<i>I hereby authorize payment of the group benefits payable to me directly or to the provider shown on the attached bill or receipt for the treatment(s) or service(s) described. I understand I may be financially responsible for charges not covered by this assignment. I also confirm that none of the attached expenses were reimbursed under any other health coverage, including any Flexible Spending Account (FSA), Health Savings Account (HSA) or Health Reimbursement Arrangement (HRA).</i>	

I certify that the information on the form and all supporting documents are complete, accurate and unaltered.

Signature: \_\_\_\_\_  
Signature of Employee
Date Signed

Submit this completed form and your supporting documentation to:

Health Plans, Inc. — Corporate Headquarters • PO Box 5199 • Westborough, MA 01581 • 800-532-7575 • 508-792-1188 (fax)