# Member Reimbursement Form

WellSense HEALTH PLAN

You must be a member of WellSense Senior Care Options at the time the service is rendered and your receipt must be for covered services. Reimbursement requests should be submitted within one year of the date of service. Please contact Member Services at 855-833-8125 (TTY users should call 711) if you have any questions.

## Member information (please print information clearly)

Member ID Number (Found on your member ID card)

Last Name

First Name | Middle initial

| Address | City | State | Zip code |
|---|---|---|---|
| | | | |

Phone

## Service information

Name of provider:

Date of service:

Address and phone number of provider (if known):

In what setting did you receive treatment? (e.g., office, ER, hospital, clinic, etc.)

Amount of reimbursement you are requesting: $

**If services were performed outside of the USA:**

In what country were services performed?

In what language was the bill/ receipt written?

In what currency was the bill paid?

Describe the items or services that you were seen for (e.g. asthma, lab work, ER visit, flu shot, eyewear, durable medical equipment, etc.):

**Payment information: Check which of the following acceptable proof of payment you are attaching to this form:**

☐ A copy of the front and back of the cancelled check written to the provider or the bank encoded front of the check written to the provider

☐ A credit card statement or receipt with itemized bill and authorization, if applicable

☐ A statement from the provider, on the providers letterhead with authorized signature indicating payment was made

**(Please include proof of payment and itemized receipt)**

(Use reverse side or another sheet of paper to include any additional information if necessary)

**Certification and authorization** (This form must be signed below)

I understand that WellSense may seek additional information from providers regarding this claim. I certify that the information provided in support of this submission is complete and correct and that I have not previously submitted or received reimbursement for these services.

Member's signature

Date

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

WellSense Senior Care Options
100 City Square, Suite 200
Charlestown, MA 02129

This information is available for free in other languages. Please contact our Member Services number at 855-833-8125 for additional information. (TTY users should call 711). Hours are Monday-Friday, 8:00 a.m. - 8:00 p.m. (From Oct. 1- March 31, representatives are available 7 days a week, 8:00 a.m. - 8:00 p.m.)

Esta información esta disponible gratuitamente en otros idiomas. Por favor llame a servicio al miembro al 855-833-8125 para información adicional. (Usuarios de TTY llamar al 711). El horario es de lunes a viernes de 8:00 am a 8:00 pm (desde el 1ro de octubre al 31 de marzo representantes estarán disponibles 7 dias a la semana de 8:00 am a 8:00 pm).

WellSense Senior Care Options (HMO D-SNP) is an HMO plan with a Medicare Advantage contract and a contract with the Massachusetts Medicaid program. Enrollment in WellSense Senior Care Options (HMO D-SNP) depends on contract renewal. WellSense Senior Care Options (HMO D-SNP) is a voluntary MassHealth (Medicaid) program in association with the Executive Office of Health and Human Services and the Centers for Medicare & Medicaid Services.