MEMBER REIMBURSEMENT MEDICAL CLAIM FORM

(Please complete one form per family member, per provider)

INSTRUCTIONS
1. You will need your health care provider to assist and supply information in order to complete this form. It is recommended that you bring this form with you to your consultation visit. Please also refer to the Help Sheet for additional information. 2. Please submit the completed Reimbursement Medical Claim Form along with the additional documents and receipts to the Well Sense Health Plan as soon as possible. The following documents are required. a. Member Reimbursement Medical Claim Form (Completed and Signed) b. Proof of services rendered (Itemized bill or invoice) c. Proof of payment for the services being requesting for reimbursement (Receipt, bank statement, invoice with payment details. For childbirth classes, include a certificate of course completion.) 3. The reimbursement review process takes approximately 4 to 6 weeks to complete. 4. Reimbursement will be sent by mail to the Plan subscriber at the address Well Sense Health Plan has on record. 5. Keep a copy of all receipts and documents for your own records. 6. **Timely Filing Limit:** Submit the form with receipts within 365 days from the date of service.

SUBSCRIBER INFORMATION		
Subscriber Last Name	First Name	Middle Initial

PATIENT INFORMATION		
Patient's Well Sense Health Plan ID#	☐☐☐☐☐☐☐☐☐ - ☐☐	
Patient's Last Name	First Name	Middle Initial
Date of Birth (MM/DD/YYYY)	Telephone Number	Email Address

CLAIM INFORMATION (This section must be completed. Your health care provider can assist in completing this section.)	
Health Care Provider's Name and Address	Setting where treatment was received: ☐ Outside the U.S. (describe in box below) ☐ Hospital/Urgent Care Outside the Service Area ☐ Hospital/Urgent Care Inside the Service Area ☐ Doctor's Office ☐ Laboratory/High Imaging ☐ Other: (Describe)
Provider's Telephone Number	If the service was provided outside the country, include: Name of Country: What language is the bill written? What currency was used for the payment?
National Provider Identification Number	License# and State of License

Continued on next page

MEMBER REIMBURSEMENT MEDICAL CLAIM FORM, Continued

If possible, include the itemized bill along with this completed form.

Diagnosis Code	Diagnosis Description	Date(s) of Service	Procedure Code for each service	Procedure Description	Amount Paid
					$
					$
					$
					$
					$
					$
				Total Amount Paid	$

Patient Signature is required
I attest that the above information is true and accurate and that the services were received and paid for in the amount requested as indicated above. I acknowledge that if any information on this form is misleading or fraudulent my coverage may be cancelled and I may be subject to criminal and/or civil penalties for false health care claims.

I understand that reimbursement payment will be made to the Plan subscriber and will contain information about the service (e.g., provider name, date, description of service). I also understand that Well Sense Health Plan may request any additional information it deems necessary to verify that services were received and payment was made.

Printed Name	Signature	Date

Please fold and mail this form (Including copies of required documents) to:

Well Sense Health Plan
Member Services Dept.
529 Main Street, Suite 500
Charlestown, MA 02129

Your member handbook contains a full description of your covered services, coverage exclusions, any certain benefit limitations or conditions and what cost-sharing you must pay for covered services.

If you have any questions on the reimbursement process or would like to check the status, contact Member Services at 1 (877) 957-1300. Member Services is available Monday through Wednesday, 8:00 a.m. to 8:00 p.m. and Thursday through Friday, 8:00 a.m. to 6:00 p.m.

Well Sense Health Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

ATENCIÓN: Si habla Español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-877-957-1300 (TTY: 711).

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-877-957-1300 (TTY: 711).

MEMBER REIMBURSEMENT MEDICAL CLAIM FORM HELP SHEET

FIELD NAME	DESCRIPTION
Subscriber Information	Subscriber is the person: • Who enrolls in Well Sense Health Plan and signs the membership application form on behalf of him/herself and any dependents. • In whose name the premium is paid.
Patient's Well Sense Health Plan ID#	The ID number with two digit suffix found on the front of the Well Sense Health Plan ID card, underneath the member's name.
Patient's Name	Last and first name, middle initial of the patient who received the services.
Patient Date of Birth	Date of birth with 2 digit month, 2 digit day, and 4 digit year. For childbirth class reimbursement: include the date of birth of the newborn or the mother's due date.
Provider's Name, Address, telephone number, License#, and State of License	A provider includes, but is not limited to, hospitals, physicians, optometrists, psychiatrists, licensed clinical social workers, durable medical equipment suppliers and pharmacies.
In what setting did the patient receive treatment?	Such as office, emergency room, outpatient hospital for x-rays, laboratory, inpatient hospital, clinic, medical supply store, etc.
If the services were rendered outside of the U.S.	If applicable, indicate in what country the services were provided, the language (if not English) the bill and proof of payment were written, and in what currency the bill was paid.
Diagnosis: What was the patient seen for?	Provide a diagnosis code and detailed description of illness or injury. (Example: Flu, broken leg, asthma, etc.)
Date(s) of Service	The date(s) the services were provided to the patient.
Procedures, services, or supplies provided	Provide a procedure code and detailed description. (Example: X-ray, Office visit, Leg cast, etc.)
Total Amount Paid	The total amount for which you are requesting reimbursement.
Proof of Service(s)	A document that demonstrates the service was actually rendered, listing date(s) of service, service(s) provided, and dollar amount paid.
Proof of Payment	A document that demonstrates the payment made by the member for the services provided by the health care provider or facility. Examples include: • Front and back of the cashed check written to the provider • A credit card statement or receipt • A statement from the provider on the provider's letterhead with authorized signature indicating payment was made • Receipt for purchased items or services with the provider's name and address pre-printed on the receipt, with items listed and total amount paid.

Multi-language Interpreter Services

Important! This information is about your Well Sense Health Plan benefits. It needs to be translated right away. Well Sense Health Plan can translate it for you. If you speak English, language assistance services, free of charge, are available to you. Call 877-957-1300 (TTY: 711).

هام! هذه المعلومات تتعلق بمزايا خطة Well Sense Health Plan الخاصة بك، ويتعين ترجمتها في الحال يمكن لمؤسسة Well Sense Health Plan ترجمتها لك. إذا كنت تتحدث العربية، فإن خدمات المساعدة اللغوية متوفرة لك بالمجان. اتصل برقم 877-957-1300. (TTY: 711). (ARA)

Important! Cette information est à propos de vos prestations médicales de Well Sense Health Plan. Elle doit être traduite immédiatement. Well Sense Health Plan peut la traduire pour vous. Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 877-957-1300 (TTY: 711). (FR)

¡Importante! Esta información es sobre sus beneficios de Well Sense Health Plan. Debe ser traducida inmediatamente. Well Sense Health Plan puede traducirla por usted. Si habla Español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 877-957-1300 (TTY: 711). (SP)

Σημαντικό! Οι παρούσες πληροφορίες αφορούν τις παροχές σας σχετικά με το Well Sense Health Plan. Πρέ πει να μεταφραστούν αμέσως. Το Well Sense Health Plan μπορείναταμεταφράσειγιαεσάς. Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε 877-957-1300 (TTY: 711). (GR)

重要！此資訊是關於您的Well Sense Health Plan福利。它必須立即被翻譯。Well Sense Health Plan可以為 您翻譯。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 877-957-1300 (TTY: 711)。(CHT)

Importante! Esta informação é sobre os seus benefícios do Well Sense Health Plan. Ele precisa ser traduzido imediatamente. Well Sense Health Plan pode traduzi-lo para você. Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 877-957-1300 (TTY: 711). (PORT)

Ważne! Te informacje dotyczącą korzyści zapewnianych przez Well Sense Health Plan. Konieczne jest ich natychmiastowe przetłumaczenie. Well Sense Health Plan może przetłumaczyć je dla Ciebie. Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 877-957-1300 (TTY: 711). (POL)

Važno! Ove informacije su o vašim beneficijama Well Sense Health Plan. Njihov prijevod je potreban odmah. Well Sense Health Plan može ih prevesti za vas. Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 877-957-1300 (TTY: 711). (CRO)

महत्त्वपूर्ण! यो जानकारी तपाईंको Well Sense Health Plan सुविधाहरूको बारेमा हो। यसलाई अहिले नै अनुवादन गर्नुपर्छ। Well Sense Health Plan ले तपाईंको लागि अनुवादन गर्न सक्छ। यदि तपाईं नेपाली बोल्नुहुन्छ भने भाषा सहायता सेवाहरू तपाईंको लागि नि:शुल्क उपलब्ध छ। 877-957-1300 (TTY: 711) मा फोन गर्नुहोस्। (NEP)

Lưu ý! Đây là thông tin về phúc lợi Well Sense Health Plan của bạn. Cần phải dịch ngay. Well Sense Health Plan có thể dịch nó cho bạn. Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 877-957-1300 (TTY: 711). (VIET)

Penting! Berikut ini adalah informasi tentang manfaat Well Sense Health Plan Anda. Informasi Anda harus diterjemahkan. Well Sense Health Plan dapat menerjemahkannya untuk Anda. Jika Anda menggunakan Bahasa Indonesia, kami menyediakan layanan bantuan untuk Anda secara gratis. Hubungi 877-957-1300 (TTY: 711). (IND)

중요사항! 본 정보는 귀하의 Well Sense Health Plan 수당에 대한 것으로, 즉시 번역해야 합니다. Well Sense Health Plan이 귀하를 대신해 번역해드리겠습니다. 한국어 사용자라면 언어 지원 서비스를 무료로 제공해드립니다. 877-957-1300 (TTY: 711) 로 전화하십시오. (KOR)

Notice About Nondiscrimination and Accessibility Requirements and Nondiscrimination Statement: Discrimination is Against the Law

Well Sense Health Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Well Sense Health Plan does not exclude people or treat them differently because of race, color national origin, age, disability, or sex.

Well Sense Health Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Well Sense Health Plan.

If you believe that Well Sense Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Civil Rights Coordinator
529 Main Street, Suite 500
Charlestown, MA 02129
Phone: 877-957-1300 (TTY/TDD 711)
Fax: 617-897-0805

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Well Sense Health Plan is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services 200 Independence Avenue, SW
Room 509F, HHH Building Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are also available at http://www.hhs.gov/ocr/office/file/index.html.