
This claim form is used to request reimbursement of covered expenses. Complete the information below to tell us more about your request. See your Evidence of Coverage (EOC) for benefit guidelines and reimbursement allowable amounts.

# MEMBER REIMBURSEMENT CLAIM FORM

Member ID or MBI Number: _____

Member's Name: _____

Member's Date of Birth _____

Member's Address _____

Member's Phone Number _____

Provider Name

_____
(If the Physician is part of a Group, include the name of the Physician)

Provider NPI/ Tax ID Number (Provider should provide this information)

_____

Provider telephone number _____

Date of service: (Example 09 02 2020) Month (Day) (Year)__ __ __ _

Condition or diagnosis:_____CPT Code: _____

CPT Code:_____, _____. _____. _____,_____,_____, _____._____
(Provider should provide this information)

| **Services Provided** | **$ Charges** | **$ Paid Amount** |
|---|---|---|
| Office Visit &/or Consultation | $_____ | $_____ |
| Radiology | $_____ | $_____ |
| Anesthesia | $_____ | $_____ |
| Hospital Services | $_____ | $_____ |


| | | |
|---|---|---|
| Emergency Room Services | $_____ | $_____ |
| Laboratory | $_____ | $_____ |
| Surgery | $_____ | $_____ |
| Durable Medical Equipment | $_____ | $_____ |
| Mental Health | $_____ | $_____ |
| Other (description) | $_____ | $_____ |

_____

_____

Please explain why you had to pay for the services:

_____

_____

_____

_____

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 there will be no additional payments to the provider for this/these service(s).

_____

Print Member/ Authorized Representative Name

_____ _____

Member/ Authorized Representative Signature Date

*Authorized Representatives must complete an Authorized Representative form and submit it with this claim form or have valid legal documentation on record with the health plan.

# INSTRUCTIONS FOR MEMBER REIMBURSEMENT CLAIM FORM

The reimbursement claim form must be submitted for all reimbursements.

Please be sure the information included is correct. (Example: Member ID, date of service, etc.)

The following are requirements to receive the reimbursement:

1. The form must be completed clearly.
2. Original receipt from provider including amount paid.
3. Name and telephone number of the provider.
4. Must include procedure code and diagnosis, using the corresponding code (ICD -10, CPT-4) and description and Provider name and NPI / Tax ID number. This should be available to you by contacting the servicing provider.

Please keep copy of the documents included in this claim.

Must be submitted on or before 120 days after services rendered to the following address:

Texas Independence Health Plan
P.O. Box 981733 El Paso, TX 79998
Attn: Direct Member Reimbursement

For questions or further information, please call our Member Service Department at our toll-free number 1-833-471-8447 (TTY 1-833-414-8447). Hours are 8:00 A.M. to 8:00 P.M., seven days a week from October 1 through March 31; 8:00 A.M. to 8:00 P.M. Monday to Friday from April 1 through September 30.