

# Member Reimbursement Form



The Member Reimbursement Form is not a guarantee of payment. Network Health reviews the coverage documents to ensure all provisions have been followed.

This form must be submitted within twelve (12) months of the date of service to be considered for reimbursement.

## To be completed by the Member

Member Name: \_\_\_\_\_

Member ID Number: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Group Name: \_\_\_\_\_

Group Number: \_\_\_\_\_

Date of Service: \_\_\_\_\_

## Please check one

\*Special processing instructions apply

- Dental (For employer plans that have a dental reimbursement benefit. See your Certificate of Coverage for details.)
- Durable Medical Equipment (Must be purchased from a supplier that accepts Medicare)
- Emergency care outside of the United States  
\*If services were inpatient or surgical, medical records are required.

Reason for visit: \_\_\_\_\_

Date of visit: \_\_\_\_\_

Provider/facility name: \_\_\_\_\_

Were you admitted to the hospital (inpatient)? \_\_\_\_\_

Exchange rate for date of visit, in US dollars: \_\_\_\_\_

- Flu Shot
- Glasses after cataract surgery (See your Certificate of Coverage or Evidence of Coverage for details)
- Transplant lodging and transportation (mileage between your home and the designated transplant facility and between the lodging and transplant facility.)
- Other (please specify) \_\_\_\_\_

## To ensure a faster claim review, please include the following required items.

- Receipt of payment
- Durable Medical Equipment (DME) services must include prescription from your physician
- Vision hardware must include a copy of your new prescription

## To be completed by the Provider

\*\*Please reach out to your provider for this information, or request your provider submit a claim directly to Network Health for consideration.

Provider Name: \_\_\_\_\_

Tax Identification Number (TIN): \_\_\_\_\_

National Provider Identifier (NPI): \_\_\_\_\_

ICD-10 Diagnosis Code(s): \_\_\_\_\_

CPT/HCPGS Procedure Code(s): \_\_\_\_\_

## Next Steps

Please ensure you have the following documentation.

- Completed Member Reimbursement Form
- Paid receipt for all services  
**Please note**—In order to qualify for reimbursement, receipts must show a zero-dollar balance, meaning the service or item has been paid in full
- Copy of prescription from your physician for any medical supplies and equipment, including glasses and diabetic shoes
- Lift chairs require the cost of the lift mechanism to be considered eligible

### Please mail this form to:

Network Health  
Attn: Claims Department  
PO Box 568  
Menasha, WI 54952

### Or fax this form to: 920-720-1920

If you need assistance with this form or have any questions, please contact the number on the back of your ID card.

## Member or Authorized Representative Signature

X

Date: