Member Reimbursement Form Instructions

Please note that in order to be able to review a reimbursement request accurately, the following steps must be completed. If these steps are not followed accordingly, then the request will be considered invalid or subjected to denial.

- Form must be completed accurately (Example: date of service, payment amount, diagnosis codes, and procedure codes).
- The following information must be attached to this form:
  - **Copies of itemized statement** from provider that clearly show dates of service, place of service, diagnosis codes, procedure codes, units/days, and amount charged.
  - **Copy of receipt** with the provider's name and address preprinted.
  - **Proof of payment** that includes but is not limited to bank statements, front and back of cleared check written to provider.
  - **Copies of medical records** supporting the services received.
- HealthSun Health Plans may request additional documentation when necessary.
- If the request is filled by someone other than the member, a completed appointment of representative must be submitted (please see attachment)
- Members who received emergency care outside of the US should follow up immediately with their primary care physician; a member services representative will assist you, if necessary. (Note: if medical bills were paid in a currency other than American Dollar it will be converted using currency exchange rates on Date of Service and country where services were rendered.)
- After the form is completed and supporting documentation is collected, please send all documents to the Claims Department at the address, email or fax listed below within **30 days** of date of service. If you are unable to submit this form and the additional documentation requested within 30 days; you must provide a letter of good cause for the delay.

  Attention: Claims Department
  3250 Mary Street Suite 400
  Coconut Grove, FL 33133
  Fax number: (786) 623-6655
  claimsdept_efax@healthsun.com

- **Any person who knowingly and with intent to injure, defraud, or deceive any insurer, files a statement of claim or an application containing any false or misleading information may be found guilty of a felony of the third degree**.

3250 Mary Street, Suite 400
Coconut Grove, FL 33133

Member Service Contact
Toll Free: 877-366-2069
Phone: 305-447-4458
TTY: 877-206-0500
Fax: 305-448-5783

Member Service Hours
8am – 8pm Eastern Time
Monday through Friday

ONE FORM PER MEMBER/PER PROVIDER
Please print clearly, complete all sections and sign. Retain copy for personal records.

Member Information			
Member Name:	**Date of Birth:**		
Primary Care Physician:	**Member ID:**		
Address:	**City:**	**State:**	**ZIP:**
Day Phone:	**Evening Phone:**		

Provider/Billing Information
Provider Name:
Provider Address:
Provider Phone:
Provider Tax ID#:

Additional information: Complete any information that applies.		
1) Was the above service(s) received because of an emergency?	☐ YES	☐ NO
2) Was the condition above related to an auto accident?	☐ YES	☐ NO
3) Were services above rendered out of the country?	☐ YES	☐ NO
4) Did any other insurance company pay for services received? (i.e. travel insurance)	☐ YES	☐ NO
5) Was your primary care physician notified?	☐ YES	☐ NO
6) Were you referred to the attending provider by your primary care physician?	☐ YES	☐ NO
7) Is a copy of itemized statement included with this form?	☐ YES	☐ NO
8) Is a copy of receipt included with this form?	☐ YES	☐ NO
9) Is proof of payment included with this form?	☐ YES	☐ NO
10) Are copies of medical records included with this form?	☐ YES	☐ NO

The following information must be obtained from your provider, or must be included on the itemized statement from your provider.

Dates of Service	Place of Service (Office, ER, Urgent, Hospital, Clinic, Ambulance, Home)	Diagnosis Code (DX)	Procedure Codes	Units/Days	Amount Charged in US $	Amount Paid in US $
				Total:	$	$

If amount charged was originally in currency other than US dollars, please indicate total charged amount below:	If amount paid was originally in currency other than US dollars, please indicate total paid amount below:
$	$

Please explain the circumstances regarding your reimbursement request. **Attach additional sheets if necessary.**

In what country did these services take place? (City, State and Country)

If services were rendered outside US please specify your travel dates: ____/____/______ to ____/____/______

In detail, explain the nature of the incident/accident/injury/emergency:

I certify that the above information on this form, statements written above, and all attachments are correct, complete, accurate, and true to the best of my knowledge. I attest that the services were received and paid for in the amount requested as indicated above. I authorize the Provider to release appropriate information necessary to process this claim to plan provisions. Additionally, I have read and understood the fraud statement on the front of this form and 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.

Member or Member Representative/Provider Signature:	Date:

HealthSun 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 1-877-336-2069. (TTY: 1-877-206-0500). ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-877-336-2069. (TTY: 1-877-206-0500). HealthSun Health Plans is an HMO plan with a Medicare contract. Enrollment in HealthSun Health Plans depends on contract renewal.
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