Member Reimbursement Form

Rev. 10/19/2016

Use this form for any reimbursement requests you may have if your provider is not submitting your claim. Whenever possible, claims for services provided to you by your provider must be submitted by the provider.

Please complete a separate form for each individual. Refer to your benefit information for more information on claim filing. You may need your provider to assist and supply information to complete this form. Please retain copies of all information submitted for your records. If you have questions, please call Member Services at 1-855-624-6463.

Please fill in the following information:

SUBSCRIBER INFORMATION			
Last Name	First Name	M.I.	Subscriber ID #

MEMBER (PATIENT) INFORMATION			
Last Name	First Name	M.I.	Date of Birth
			/ /

Mailing Address		Member ID #
City	State	Zip Code

PROVIDER INFORMATION	
Provider Name	Provider NPI
Group/Facility Tax ID #	Group/Facility NPI
Provider Street Address	City, State Zip
Provider Mailing Address (if different)	City, State Zip

CLAIM(S) INFORMATION

Date of Service	Diagnosis Code	Procedure Code	Modifier	# of Units	Place of Service (POS)*	Charge Amount	Paid Amount**
/ /	-					$	$
/ /	-					$	$
/ /	-					$	$
					Totals	$	$

*Please use POS # designated in the "Definitions" table **Please attach proof of payment (receipt) to verify amount paid to Provider

ATTESTATION AND SIGNATURE

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 when the reimbursement payment is made it will contain information about the service (e.g., Provider name, date, description of service). I also understand that Community Health Options may request any additional information it deems necessary to verify that services were received and/or payment was made.

Print Name	Member/Guardian Signature	Date
		/ /

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Please write your name and Member ID on all receipts and attach them to this form. Send completed form and receipts to the address below:

Community Health Options
Mail Stop 200
PO Box 1121
Lewiston, ME 04243

<table>
<tr><th colspan="2">Member Reimbursement Claim Form Definitions</th></tr>
<tr><td>Subscriber Information</td><td>Subscriber is the person:
Who enrolls in the health plan and signs the membership application form on behalf of him/herself & any dependents; and
In whose name the premium is paid.
Subscriber ID is:
The same as Primary Insured's Member ID and can be found on the front the insurance card.</td></tr>
<tr><td>Member Name</td><td>First and Last names and Middle Initial of Patient who received services.</td></tr>
<tr><td>Member Date of Birth</td><td>Date of Birth: Month (2 digits), Day (2 digits), and Year (4 digits) (e.g., MM/DD/YYYY).</td></tr>
<tr><td>Member ID #</td><td>Identification # + suffix found on the front of member's insurance card.</td></tr>
<tr><td>Provider Information</td><td>Provide the information for the Provider that was seen for services.</td></tr>
<tr><td>Date(s) of Service</td><td>The date(s) the services were provided to the patient.</td></tr>
<tr><td>Diagnosis Code(s)</td><td>Code used to identify what the member was seen for.</td></tr>
<tr><td>Procedure Code(s)</td><td>Code used to identify what services were provided to the member.</td></tr>
<tr><td>Place of Service</td><td>In what setting did the patient receive services:
<table>
<tr><th>POS #</th><th>POS DESCRIPTION</th></tr>
<tr><td>11</td><td>Office</td></tr>
<tr><td>17</td><td>Walk-in Retail Health Clinic</td></tr>
<tr><td>20</td><td>Urgent Care Facility</td></tr>
<tr><td>21</td><td>Inpatient Hospital</td></tr>
<tr><td>22</td><td>Outpatient Hospital</td></tr>
<tr><td>23</td><td>Emergency Room – Hospital</td></tr>
<tr><td>49</td><td>Independent Clinic</td></tr>
<tr><td>50</td><td>Federally Qualified Health Center</td></tr>
<tr><td>51</td><td>Inpatient Psychiatric Facility</td></tr>
<tr><td>52</td><td>Psychiatric Facility-Partial Hospitalization</td></tr>
<tr><td>56</td><td>Psychiatric Residential Treatment Center</td></tr>
<tr><td>57</td><td>Non-residential Substance Abuse Treatment Facility</td></tr>
<tr><td>61</td><td>Comprehensive Inpatient Rehabilitation Facility</td></tr>
<tr><td>62</td><td>Comprehensive Outpatient Rehabilitation Facility</td></tr>
<tr><td>99</td><td>Other Place of Service</td></tr>
</table></td></tr>
<tr><td>Charge Amount</td><td>Amount charged by Provider for services rendered</td></tr>
<tr><td>Total Paid Amount</td><td>Total amount for which you are requesting reimbursement</td></tr>
<tr><td>If services were rendered outside of the U.S.</td><td>If applicable, indicate in what country services were provided, in what language the bill was written and in what currency the bill was paid.</td></tr>
</table>

NON-DISCRIMINATION NOTICE

Community Health Options does not view or treat people differently because of their race, color, national origin, sex, age or disability. If you need help with any of the information we provide you, please let us know. We offer services that may help you. These services include aids for people with disabilities, language assistance through interpreters and information written in other languages. These are free at no charge to you. If you need any of these services, please call us at the number on the back of your member ID card.

If you feel at any time that we didn't offer these services or we discriminated based on race, color, national origin, sex, age or disability, please let us know. You have the right to file a grievance, also known as a complaint. If you need help filing a complaint, please contact Nancy Johnson, Assistant Vice President of Compliance and Regulatory Affairs at P.O. Box 1121, Lewiston, ME 04243; by telephone at 1-855-624-6463 TTY/TDD 711; by email at Compliance@healthoptions.org; or by fax to 207-402-3318.

You can also contact the U.S. Department of Health and Human Services at the Office for Civil Rights at:

- Online: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
- Mail: U.S. Department of Health and Human Services
  200 Independence Avenue SW
  Room 509F, HHH Building
  Washington, DC 20201
- Phone: 1.800.368.1019 or 1.800.537.7697 (TDD)
- Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

French ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposes gratuitement. Appelez le 1-855-624-6463 (TTY/TDD: 711)	**Spanish** ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-624-6463 (TTY/TDD: 711)	**Chinese** 注意：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 1-855-624-6463 (TTY/TDD: 711)。
Cushite XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-855-624-6463 (TTY/TDD: 711)	**Vietnamese** CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-855-624-6463 (TTY/TDD: 711)	**Arabic** ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن الخدمات المساعدة اللغوية متاحة لك مجانا. اتصل برقم 1-855-624-6463 (TTY/TDD 711: رقم الصم والبكم).
Cambodian, Mon-Khmer យកចិត្តទុកដាក់: ប្រសិនបើអ្នក កនិយាយភាសា ខ្មែរ, ជាសេវាគាំទ្រភាសាគឺអាចរកបានដោយឥតគិតថ្លៃ។ សូមទូរស័ព្ទ: 1-855-624-6463 (711 TTY / TDD) ។	**Russian** ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-855-624-6463 (телетайп: 711)	**Tagalog** PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1855-624-6463 (TTY/TDD: 711).
German ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-855-624-6463 (TTY/TDD: 711).	**Thai** ือียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-855-624-6463 (TTY/TDD: 711).	**Nilotic-Dinka** PIŊ KENE: Na ye jam në Thuɔŋjaŋ, ke kuɔny yenë kɔc waar thook atɔ kuka lëu yök abac ke cïn wënh cuatë piny. Yuɔpë 1-855-624-6463 (TTY/TDD: 711).
Korean 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-855-624-6463 (TTY/TDD: 711)번으로 전화해 주십시오.	**Polish** UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-855-624-6463 (TTY/TDD: 711).	**Japanese** 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-855-624-6463（TTY/TDD: 711）まで、お電話にてご連絡ください。