2021 Financial Incentive Claim

Members enrolled in a small group HSA plan may qualify for a financial incentive if they shop for and receive certain health care from a low-cost, high-quality, In-Network Providers. Health Options will provide a financial incentive for each covered service which qualifies for our Financial Incentive Program. You may apply for the Financial Incentive Program by completing this form.

The following services are eligible for financial incentives:

1. Physical and occupational therapy; radiology and imaging; and laboratory service financial incentive: Covered services include a set of Current Procedural Terminology (CPT) codes within each of three categories of services: physical and occupational therapy (97161, 97162, 97163, 97001, 97165, 97166, 97167, 97003 and 97110); radiology and imaging (72148, 73221 and 73721); and laboratory services (80061, 84443, and 85025).

If you shop for these services and elect to receive covered services from a low-cost, high-quality, In-Network Provider, you may quality for a $5.00 gift card. The program is limited to the identified, covered services within the three service categories and to a maximum number of services per calendar year (four for CPT code 97110 and one for all other CPT codes).

2. Home infusion drug therapy financial incentive: Covered services include a set of Healthcare Common Procedure Coding System (HCPCS) codes for the medications Actemra (generic name tocilizumab) HCPCS J3262, Inflectra (generic name infliximab) HCPCS Q5103, Renflexis (generic name infliximab) HCPCS Q5104, Remicade (generic name infliximab) HCPCS J1745, and Stelara (generic name ustekinumab) HCPCS J3358. If you shop for any the above medications and receive your infusion drug therapy in your home from a low-cost, high-quality, In-Network Provider, you may qualify for a $100.00 gift card. The program is limited to the identified, covered services and to a maximum number of services per calendar year (one per HCPCS code).

NOTE: The infusion therapy drugs subject to this program are only available after receipt of Prior Authorization from our Medical Management team.

How to Request a Financial Incentive

IMPORTANT: Only small group HSA plan Members are eligible for this incentive. You must be enrolled in one of the following plans to qualify:

Community Access HSA Community Option HSA Community Basic HSA Community Beacon HSA
Community Core HSA Community Balance HSA Community Summit HSA Community Peak HSA (PY '20)

If you qualify for this incentive and have received one of the services indicated above, you must compare the "allowed amount" for that service as noted on your Explanation of Benefits (EOB) to the "Maine State Average" for that service as noted on the website CompareMaine (comparemaine.org). If the allowed amount for the service you received is less than the Maine state average, you may qualify for a gift card.

The CPT code or HCPCS code for the service you received must match one of the CPT or HCPCS codes listed above. Please confirm with your provider the CPT or HCPCS code used in the claim submission, and include that code on the form that follows.

Complete, sign, and date the form on the next page, and return to:

Community Health Options
Mail Stop 100
PO Box 1121
Lewiston, ME 04243

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Please fill in the following information:

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

Your Plan:
☐ Community Access HSA ☐ Community Option HSA ☐ Community Basic HSA ☐ Community Beacon HSA
☐ Community Core HSA ☐ Community Balance HSA ☐ Community Summit HSA
☐ Community Peak HSA (PY '20)

PATIENT INFORMATION (IF DIFFERENT FROM SUBSCRIBER)			
Last Name	First Name	M.I.	Date of Birth
			/ /
Mailing Address			Member ID #
City	State		Zip Code

PROVIDER INFORMATION
Provider Name
Facility or Practice Name

CLAIM(S) INFORMATION				
Date of Service	Claim Number	CPT or HCPCS Code	Allowed Amount (on EOB)	Maine State Average (per comparemaine.org)
/ /			$	$
/ /			$	$
/ /			$	$
/ /			$	$
/ /			$	$
/ /			$	$

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
		/ /

Preferred Gift Card

☐ Walmart ☐ Amazon