CarePartners of Connecticut
MEDICARE ADVANTAGE

# Member Reimbursement Form

This form allows CarePartners of Connecticut members to request reimbursement for covered health care services you have received and paid out-of-pocket (including out-of-country health care services). **Please note:** This form is not intended to be used for Weight Management reimbursement (HMO only) or for non-plan vision provider reimbursements through EyeMed Vision Care.

If a Member Reimbursement Form is being submitted by an Authorized Representative, please complete and include the *Appointment of Representative (AOR) Form*, or any legal documentation verifying personal representation, with your request. We require verification of the authority of an Authorized Representative before the request can be processed. You can find the AOR Form on our website at **carepartnersct.com/aor**.

☐ **I am completing this form as an Authorized Representative to the subscriber.**

## Member Information

First name | M.I. | Last name

Date of birth | Member ID number

Plan type
◯ HMO
◯ PPO


Find your plan type on your member ID card.

## Service Information (Include any additional information on separate sheet)

Name of service provider

Street address

City | State | ZIP

**IF SERVICES WERE PERFORMED OUTSIDE USA**

Country of service

Language of bill/receipt | Currency of bill

In what setting did you receive treatment?

◯ Office ◯ ER ◯ Hospital ◯ Clinic ◯ Other

Describe the items/services received[1]
(e.g., lab work, ER visit, flu shot, eyewear, durable medical equipment,[2] dental services, etc.)

Service date(s)

Procedure code (optional)

## Reimbursement Information

Amount of reimbursement you are requesting

$ _____ . ____ ☐ Amount is in another currency (as specified on page 1)

**Please include proof of payment and itemized receipt.[3]**

Check which of the following acceptable proof of payment you are attaching to this form

- ◯ A copy of the front and back of the cancelled check written to the provider or the bank encoded front of the check written to the provider.
- ◯ A credit card statement or receipt with itemized bill and authorization, if applicable.
- ◯ A statement from the provider, on the provider's letterhead with authorized signature, indicating payment was made.

## Signature

**I attest that the information is accurate and complete.**

Signature _____ Date _____

## Instructions

**Please mail this completed form to:**

**CarePartners of Connecticut, Inc.**
Member Reimbursement
P.O. Box 518
Canton, MA 02021-0518

**For more information:**

Call Member Services at
**1-888-341-1507 (HMO)/**
**1-866-632-0060 (PPO) (TTY: 711)**
8 a.m.–8 p.m., 7 days a week
(Mon.–Fri. from Apr. 1–Sept. 30).

[1]CarePartners of Connecticut may require prior authorization for certain services and items, including drugs, devices, and equipment as a condition of payment. Refer to your Evidence of Coverage booklet for your plan's guidelines.

[2]Prescription required for durable medical equipment purchase.

[3]A receipt for purchased items, with the provider's name and address preprinted on the receipt, with items listed and the amount paid.