CarePartners of Connecticut

Member Reimbursement Form

This form allows CarePartners of Connecticut plan members to request reimbursement for any health care services you have received that were not initially covered by CarePartners of Connecticut (including out-of-country health care services). **Please note:** this form is not intended to be used for weight management reimbursements or non-plan vision provider reimbursements through Eyemed.

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

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

Member Information

First name | MI | Last name | Date of birth

Member ID number

Service Information (include any additional information on separate sheet)

Name of service provider | Phone

Street address | City/town | State | Zip

If services were performed outside of the USA: Country of service | Language of bill/receipt | Currency of bill

In what setting did you receive treatment?

○ Office ○ Clinic ○ Hospital ○ ER Other

Describe the items/services received* *(e.g. asthma, lab work, ER visit, flu shot, eye-wear, durable medical equipment† , dental work, etc.)*

Service date(s) or range of dates

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‡

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

A copy of the front and back of the canceled 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.

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 9183
Watertown, MA 02471-9183

For more information, call Customer Service at **1-888-341-1507 (TTY: 711).**

Representatives are available Monday–Friday, 8 a.m.–8 p.m. (October 1–March 31, representatives are available 7 days a week, 8 a.m.–8 p.m.) After hours and on holidays, please leave a message and a representative will return your call on the next business day.

* CarePartners of Connecticut requires prior authorization for certain drugs, devices, and equipment as a condition of payment. Refer to your Evidence of Coverage booklet for your plan's guidelines.

† Prescription required for Durable Medical Equipment purchase.

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