# Medicare Advantage Claim Reimbursement Form for COVID-19 Telemedicine Services

This form is used for members who have paid out of pocket for telemedicine medical services and are requesting reimbursement. You must submit your claim to us within 365 days of the date you received medical services.

As part of Bright Health Plan's response to the COVID-19 crisis, telemedicine benefits have been expanded to all service providers. COVID-19 screening is covered at no charge. All other appointment types are covered at the in-person appointment rates as designated by your plan.

## **Instructions:**

 Complete this form and attach your bill, receipts and any other documentation related to this reimbursement request. Forms without the required information may delay the processing of your request.

IMPORTANT: This information must be on the bill or invoice you submit as it is required to process the claim. Missing information can result in a delay or non-payment of the claim.

- Name and address of provider (doctor, hospital, laboratory, ambulance service, Tax ID, etc.)
- Name of patient
- Procedure Codes
- · Date of service
- Amount charged for each service
- · Diagnosis code

If you do not have a document with this information, ask your provider to give you a bill or invoice that includes all of the above for each date of service.

2. Once you have completed the form, mail it to:

Bright Health Medicare Advantage-Claims PO Box 853960 Richardson, TX 75085-3960

Be sure to attach the invoice or bill and any receipts of your payments.

### What happens next:

- It can take up to 60 days to process the claim submission
- After we process your claim, we will send you and Explanation of Payment (EOP) with a check for applicable reimbursement based on your plan benefits.



For questions, call 855-521-9342.



# **Member Claim Form**



Please use a separate claim form for each patient. Your cooperation in completing all items on the claim form and attaching all required documentation will help expedite quick and accurate processing. SEE REVERSE SIDE FOR COMPLETE INSTRUCTIONS.

Section A. PATIENT INFORMATION														
Last name Fire					irst name									
Does the patient have other health insurance of	coverage? Rel	ation to	subscrib	er		Sex	Da	ate of	birth	(MI	//DD	/YYYY)		
☐ Yes ☐ No		☐ Self ☐ Spouse☐ Son ☐ Daughter ☐ M ☐ F					]F							
Name of other health insurance company Grou		•	Employ	imployer name				Policy no.						
Section B. SUBSCRIBER INFORMATION (on Bright Health ID Card)														
Identification no.					Group no.									
Last name Fir				irst name M.I.										
Street address (please include apt. no.)														
City	1 1			1		1 1		Sta	te	ZIP	code	•		
lome phone no. Work phone no.				0.						Date of birth (MM/DD/YYYY)				
Section C. MEDICAL INFORMATION														
HEALTH CARE SERVICES: Use this section to report any COVERED health service that has not already been reported to this Bright Health Plan by the provider of service (the physician, clinical, ambulance company, private duty nurse, etc.) Attach itemized bill or photocopy. Please be sure that duplicate bills are not submitted.  Was this medical expense the result of an accident?														
Diagnosis code			rocedure	oodo				Λmo	unt Ch	orac	.d			
Diagnosis code	Date of Service Proceed			edure code					Amount Charged					
BILLS MUST BE ITEMIZED  Cancelled checks, cash register receipts and non-itemized "balance due" statements cannot be processed. Each itemized bill must include:  • Name and address of provider (doctor, hospital, laboratory, ambulance service, Tax ID, etc.)  • Name of patient  • Procedure code  • Date of service  • Amount charged for each service  • Diagnosis code														
I certify that, to the best of my knowledge, the information on this Member Claim Form is true and correct. I authorize the release of any medical information necessary to process this claim.														
Signature <b>X</b>	Name			D					Date					

#### **HOW TO USE THIS FORM**

Most health care providers will submit bills to Bright Health on you or your dependent's behalf. However, if a physician does not bill us they may bill you directly. If you receive a bill from your a health care provider you may use this claim form to submit the charges to Bright Health.

Please read the following instructions for submitting the claim to report the claim to Bright Health.

#### **SECTION A. PATIENT INFORMATION**

Use this section to identify the patient.

#### SECTION B. SUBSCRIBER INFORMATION (on Bright Health ID card)

Use this section to identify the subscriber. Some of this information may be found on your Bright Health card.

SECTION C. MEDICAL INFORMATION: This section pertains to the employee through whose employer your program is obtained

**Health Care Services:** Use this section to report that has not already been reported to Bright Health. Attach a photocopy of an itemized bill.

#### **MEMBER CLAIM FORM INSTRUCTIONS:**

Please mail this claim form and a photocopy of your itemized bill to:

Bright Health Medicare Advantage-Claims PO Box 853960 Richardson, TX 75085-3960