Medicare Reimbursement Claim Form

This form is used for members who have paid out of pocket for medical services and are requesting reimbursement.

- 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.

- You must submit your claim to us within 12 months of the date you received medical services.

- Mail request to:
  Bright Health
  Medicare Advantage-Claims
  PO Box 853960
  Richardson, TX 75085-3960

- **For questions, call Bright Member Services (844) 202 - 4129 (TTY: 711)**
  8 am – 8pm local time, Monday through Friday, except federal holidays.

Member Information

Name:	Date of Birth:
Member ID #	Phone #:

Billing Information

Date of Service	Description of Service	Amount of Expense

Comments

In order to be eligible for reimbursement, the services must be covered under your Medicare Advantage plan. Coverage is subject to the benefit limitations in your Evidence of Coverage.

To my knowledge, the statements I have submitted on this form are true and complete.

Signature _____ Date _____