Member Reimbursement Form – Medicare Advantage

WellSense HEALTH PLAN

You must be a member of WellSense Medicare Advantage HMO or PPO at the time the service is rendered and your receipt must be for covered services. This form should not be used for premiums, late enrollment penalties, or costs not related to your medical care. Reimbursement requests should be submitted within one year of the date of service. Please contact Member Service at 855-833-8128 (TTY users should call 711) if you have any questions.

Member information (please print information clearly)

Member ID Number (Found on your member ID card)

Last Name

First Name | Middle initial

Address	City	State	Zip code

Phone

Service information

Name of provider:

Date of service:

Address and phone number of provider (if known):

In what setting did you receive treatment? (e.g., office, ER, hospital, clinic, etc.)

Amount of reimbursement you are requesting: $

If services were performed outside of the USA:
In what country were services performed?

In what language was the bill/ receipt written?

In what currency was the bill paid?

Describe the items or services that you were seen for (e.g. ER visit, urgent care visit, etc.):

Payment information: 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 providers letterhead with authorized signature indicating payment was made

(Please include proof of payment and itemized receipt)

(Use reverse side or another sheet of paper to include any additional information if necessary)

Certification and authorization (This form must be signed below)

I understand that WellSense may seek additional information from providers regarding this claim. I certify that the information provided in support of this submission is complete and correct and that I have not previously submitted or received reimbursement for these services. I certify that I understand that any person who knowingly files a claim containing false or misleading information may be guilty of fraud and is subject to criminal or civil penalties.

Member's signature

Date

Member Reimbursement Form – Medicare Advantage

Please mail this form (including copies of required documents) to:

WellSense Medicare Advantage
100 City Square, Suite 200
Charlestown, MA 02129

This information is available for free in other languages. Please contact our Member Service number at 855-833-8128 for additional information. (TTY users should call 711). Hours are Monday-Friday, 8:00 a.m. - 8:00 p.m. (From Oct. 1- March 31, representatives are available 7 days a week, 8:00 a.m. - 8:00 p.m.).

Out-of-network/non-contracted providers are under no obligation to treat Plan members, except in emergency situations. Please call our customer service number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services.

Esta información esta disponible gratuitamente en otros idiomas. Por favor llame a servicio al miembro al 855-833-8128 para información adicional. (Usuarios de TTY llamar al 711). El horario es de lunes a viernes de 8:00 am a 8:00 pm (desde el 1ro de octubre al 31 de marzo representantes estarán disponibles 7 dias a la semana de 8:00 am a 8:00 pm).

Los proveedores fuera de la red/sin contrato no están obligados a tratar a los miembros del plan, excepto en situaciones de emergencia. Llame al número de servicio al cliente o consulte su Evidencia de cobertura para obtener más información, incluido el costo compartido que se aplica a servicios fuera de la red.