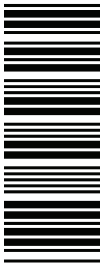
Member Reimbursement Claim Form



This form may be used for Health Net Medicare products.

Important: Complete a separate Member Reimbursement Claim Form for each member asking for reimbursement for covered services and for each doctor and/or facility.

To avoid processing delays, please include the following information with this form:

- Copy of itemized bill showing all services received. Must include name, address, phone number, and tax ID number of doctor and/or facility and all diagnosis and procedure codes.
- Proof of payment.[1] (Keep a copy of all receipts and documents for your records.)
- If a member's representative completes this form, please fill out an Appointment of Representative (AOR) Form and attach it to the submission.

Mail all medical claims to:
Health Net Medicare Claims
PO Box 9040
Farmington, MO 63640-9040

Any missing information may cause a delay in processing your request.

Section 1: Member information – Please complete a separate form for each person who received services:

Last name:

First name:

Middle initial:

Member ID #:

Birth date:

M M D D Y Y Y Y

Home phone number: – –

Email address:

Address:

City:

State:

ZIP code:

(continued)

[1]"Proof of Payment" includes, but is not limited to: a copy of the credit card charge slip, a cruise ship statement, canceled checks, a bank account statement, cash withdraw slips, or anything else that shows dates that match the medical service date. A valid receipt or doctor's statement is also acceptable if it shows the amount the member paid.

Section 2: Other insurance – Complete if it applies.

Is the member also covered by other medical insurance at this time?
☐ Yes *(Complete information below.)* ☐ No

Name of insurance company:

Policy #:

Subscriber/Member ID #:

Does this member have Medicare coverage?
☐ Yes ☐ No

Section 3: Services received – If services were received outside the U.S., please also complete Section 4.

Name of doctor and/or facility:

Phone number of doctor and/or facility:

Address of doctor and/or facility:

City:

State:

ZIP code:

Date of service:

M M D D Y Y Y Y

Amount requested to be reimbursed:

Medical description or nature of illness or injury:

Medical information authorization and release

I hereby authorize any physician, health care practitioner, hospital, clinic, or other medically related facility (as listed above) to furnish to Health Net, its agents, designees, or representatives any and all information pertaining to medical treatment for purposes of reviewing, investigating or evaluating applications or claims. I also authorize Health Net, its agents, designees, or representatives to disclose to a hospital or health care service plan, insurer or self-insurer any such medical information obtained if such disclosure is necessary to allow the processing of any claim. If my coverage is under a Group Benefit Agreement held by my employer, an association, trust fund, union, or similar entity, this authorization also permits disclosure to them to the extent necessary for utilization review or financial audit purposes. This authorization shall become effective immediately and shall remain in effect as long as Health Net is asked to process claims under my coverage. A photostatic copy of this authorization shall be considered as effective and valid as the original. I hereby certify that the above statements are correct.

Name of person completing form (please print):

Signature:

Date:

M M D D Y Y Y Y

Relationship – description of authority to act on behalf of the member, if applicable:

(continued)

Section 4: Foreign claims questionnaire

If you received health care services while traveling outside of the United States, or on a cruise in foreign or domestic waters, you'll need to complete this section. Be sure to answer every question so your claim can be processed quickly. Please provide all available documents for services received.

What dates were you traveling out of the country?

What was the nature of your emergency resulting in medical treatment?

How long were you ill before you received medical attention?

Were you admitted into the hospital?
☐ Yes ☐ No

If treated as an outpatient, how many times did you see the doctor?

Name of the hospital, clinic or doctor's office where you received treatment:

Date(s) of admission:

Address:

City:

ZIP code:

Country:

Phone number:

Name of treating physician:

Phone number:

Did you receive diagnostic tests?
☐ Yes ☐ No

If "Yes," what type?

Were surgical procedures performed?
☐ Yes ☐ No

If "Yes," what type?

Was your primary doctor in the U.S. notified?
☐ Yes ☐ No

If "Yes," when?

Note: Only covered benefits or those deemed medically necessary will be considered for reimbursement.

Any person who knowingly presents a false or fraudulent claim for the payment of a loss may be guilty of a crime, and may be subject to criminal and civil penalties.

Health Net is contracted with Medicare for HMO, HMO SNP and PPO plans, and with some state Medicaid programs. Enrollment in Health Net depends on contract renewal.

FRM063565EC00 (8/23)

Section 1557 Non-Discrimination Language

Notice of Non-Discrimination

Health Net complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Health Net:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats).
- Provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages.

If you need these services, contact Health Net's Member Services at: **1-800-275-4737** (TTY: **711**). From October 1 to March 31, you can call us 7 days a week from 8 a.m. to 8 p.m. From April 1 to September 30, you can call us Monday through Friday from 8 a.m. to 8 p.m. A messaging system is used after hours, weekends, and on federal holidays.

If you believe that Health Net has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance by calling the number above and telling them you need help filing a grievance; Health Net's Member Services is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf** or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington, DC 20201, **1-800-368-1019** (TDD: **1-800-537-7697**).

Complaint forms are available at **http://www.hhs.gov/ocr/office/file/index.html**.

Multi-Language Insert

Multi-Language Interpreter Services

Spanish: Contamos con servicios de interpretación gratuitos para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para obtener un intérprete, llámenos al **1-800-275-4737** (TTY: **711**). Alguien que habla español puede ayudarle. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费翻译服务，以便回答您可能对我们的健康或药物计划提出的任何问题。如需翻译，请拨打电话 **1-800-275-4737**（TTY：**711**）。会说汉语普通话的人员可为您提供帮助。此项服务免费。

Chinese Cantonese: 我們提供免費口譯服務，可回答您任何關於我們健康或藥物計劃的問題。若要取得口譯服務，請致電**1-800-275-4737** (TTY：**711**)。會説粵語的人員可以幫助您。此為免費服務。

Tagalog: Mayroon kaming libreng serbisyo ng tagasalin para sagutin ang anumang mga tanong na mayroon ka tungkol sa aming health o drug plan. Para kumuha ng tagasalin, tawagin lang kami sa **1-800-275-4737** (TTY: **711**). May nagsasalita ng Tagalog na puwedeng tumulong sa iyo. Ito ay libreng serbisyo.

French: Nous disposons de services d'interprétation gratuits pour répondre à toutes les questions que vous pouvez avoir sur notre régime de santé ou de médicaments. Pour entrer en contact avec un interprète, il suffit de nous appeler au **1-800-275-4737** (TTY : **711**). Une personne qui parle français peut vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch viên miễn phí để trả lời mọi câu hỏi quý vị có thể có về chương trình thuốc hoặc chương trình sức khỏe của chúng tôi. Để yêu cầu thông dịch viên, chỉ cần gọi cho chúng tôi theo số **1-800-275-4737** (TTY: **711**). Nhân viên nói tiếng Việt sẽ hỗ trợ quý vị. Dịch vụ này được miễn phí.

German: Unser kostenloser Dolmetscherdienst beantwortet mögliche Fragen zu Ihrem Gesundheits- oder Medikamentenplan. Wenn Sie einen Dolmetscher benötigen, rufen Sie uns gerne unter der folgenden Rufnummer an: **1-800-275-4737** (TTY: **711**). Sie erhalten Hilfe in deutscher Sprache. Dieser Service ist für Sie kostenlos.

Korean: 당사의 건강 또는 의약품 플랜과 관련해서 물어볼 수 있는 모든 질문에 답변하기 위한 무료 통역 서비스가 있습니다. 통역사가 필요한 경우, **1-800-275-4737**(TTY: **711**)번으로 당사에 문의해 주십시오. 한국어를 구사하는 통역사가 도움을 드릴 수 있습니다. 통역 서비스는 무료로 제공됩니다.

Russian: Если у вас возникли какие-либо вопросы о нашем плане медицинского страхования или плане с покрытием лекарственных препаратов, для вас предусмотрены бесплатные услуги переводчика. Чтобы воспользоваться услугами переводчика, просто позвоните нам по номеру **1-800-275-4737** (TTY: **711**). Вам поможет сотрудник, владеющий русским языком. Эта услуга предоставляется бесплатно.

Arabic: نوفّر خدمات ترجمة فورية مجانية للإجابة على أي أسئلة قد تكون لديك حول خطة الصحة أو الدواء الخاصة بنا. للحصول على مترجم فوري، ما عليك سوى الاتصال بنا على الرقم **1-800-275-4737** (TTY: **711**). يمكن أن يساعدك شخص يتحدث العربية وهذه الخدمة مجانية.

Hindi: हमारे पास अपने हेल्थ या ड्रग प्लान को लेकर संभवतः आपके मन में उठने वाले सवालों के जवाब देने के लिए मुफ़्त में दुभाषिया सेवाएं हैं. दुभाषिया पाने के लिए, बस **1-800-275-4737** (TTY: **711**) पर हमें कॉल करें. हिंदी जानने वाला कोई व्यक्ति आपकी मदद करेगा. यह सेवा मुफ़्त में है.

Italian: Sono disponibili servizi di interpretariato gratuiti per rispondere a qualsiasi domanda possa avere in merito al nostro piano farmacologico o sanitario. Per usufruire di un interprete, è sufficiente contattare il numero **1-800-275-4737** (TTY: **711**). Qualcuno la assisterà in lingua italiana. È un servizio gratuito.

Portuguese: Temos serviços de intérprete gratuitos para responder a quaisquer dúvidas que possa ter sobre o nosso plano de saúde ou medicação. Para obter um intérprete, contacte-nos através do número **1-800-275-4737** (TTY: **711**). Um falante de português poderá ajudá-lo. Este serviço é gratuito.

French Creole: Nou gen sèvis entèprèt gratis pou reponn nenpòt kesyon ou ka genyen sou plan sante oswa medikaman nou an. Pou jwenn yon entèprèt, jis rele nou nan **1-800-275-4737** (TTY: **711**). Yon moun ki pale Kreyòl-Franse ka ede w. Sa a se yon sèvis gratis.

Polish: Dysponujemy bezpłatnymi usługami tłumaczeniowymi w celu odpowiedzi na dowolne pytania dotyczące naszych planów zdrowotnych i lekowych. Aby uzyskać pomoc tłumacza, zadzwoń pod numer **1-800-275-4737** (TTY: **711**). Osoba mówiąca po polsku może Ci pomóc. Ta usługa jest bezpłatna.

Japanese: 無料の通訳サービスを利用して、健康や医薬品に関するご質問にお答えします。通訳をご希望の場合は、**1-800-275-4737**（TTY: **711**）までお電話ください。日本語話者がお手伝いいたします。このサービスは無料です。