1991 Marcus Avenue, Suite M201, Lake Success, NY 11042
agewellnewyork.com | Toll Free **1-866.586.8044** | TTY/TDD **1-800.662.1220**

# Member Reimbursement Form

Please Print

**A. Member Information** SEE INSTRUCTIONS SHEET ON HOW TO COMPLETE THIS FORM

| **Member Name** (*Last, First MI.*) | **Member ID Number** | **Telephone No:** (_______) __________ - ____________ Area Code |
|---|---|---|
| **Street Address:** | | |
| **City:** | **State/Zip Code:** | **Date of Birth:** ________ _________ ___________ MM DD YYYY |

**B. Physician Information:** Complete this section about the treating provider.

| **Provider Name:** | **Telephone No:** (_______) __________ - ____________ Area Code |
|---|---|
| **Address** (*Street, City, State, Zip*) | |

**C. Claim Information:** Complete this section to assist us in processing the claim.

| Date of Service | Reason for reimbursement request | Procedure Code | Charged Amount | Your Out of Pocket Amount |
|---|---|---|---|---|
| **Claim#1 Date of Service:** | | | | |
| **Claim#2 Date of Service:** | | | | |
| **Claim#3 Date of Service:** | | | | |

**Acknowledgement:**
I certify that the information furnished in conjunction with this claim is true and correct. I know it is a crime to fill out this form with falsified information. I understand that submission of a claim is not guarantee of payment of the full amount. If the services are deemed covered services then AgeWell New York will reimburse me their cost share minus any applicable deductible, coinsurance, copayments and/or out-of-network member cost sharing. I understand that the provider will not be paid for this/these service(s).

_____________________________________________ _______________________________

Member/ Authorized representative Signature Date

Any Authorized Representatives must complete an Appointment of Representative (AOR) Form and submit it with this Reimbursement Form or have one on record with the health plan.

# <u>HOW TO COMPLETE THIS REQUEST FOR REIMBURSEMENT</u>

1. **The Member or Authorized Person must complete the following sections of the Request for Reimbursement Form:**
   - Member Information, Physician Information, and Claim Information sections
   - Signature of the Member or Appointment of Representative (AOR) form. **<u>This form must be signed to process</u>**
   - Proof of Payment that shows your name must be attached, i.e., Doctor's receipt, Credit Card Receipt, Cancelled Check (front and Back), etc.

**Note:** Please be sure to include all of the required information for your request to be processed without delay.

2. **When to Submit the request for reimbursement form:**

Failure to submit the request for reimbursement within the 365 days would require you to submit a written appeal to your health plan showing good cause for the delay in filing the claim. Please contact Customer Service at the number listed on the back of your ID card if you have any questions about completion of this form or if you wish to file an appeal. Appeals instructions are included in your Evidence of Coverage.

3. **Situations in which you should ask the plan to pay our share of the cost of your covered services:**

This form should be used in certain instances, for example:

- If you are required to pay the full cost right away from a participating provider
- If you believe you have paid more than you expected under AgeWell New York's rules of coverage
- If you received emergency or urgently needed medical care from a non-participating provider

4. **Payment of Claims**

When we receive your request for payment, we will let you know if we need additional information from you. We will consider your request and decide whether to pay it and how much we owe. If the services are approved we will pay you for our share of the cost minus any applicable deductible, coinsurance, copayments and/or out-of-network member cost sharing. If we decide that the medical care is not covered, or you did not follow all of the plan rules, we will not pay for our share of the cost. You will receive a written explanation of benefit(s) with the reason(s) for the denied payment and your rights to appeal that decision, as explained above.

5. **Submission of the Completed Form:**

Return the completed form and applicable receipt(s) to the address below:

**AgeWell New York, LLC**
**Claims Department**
**1991 Marcus Avenue Suite M201**
**Lake Success, New York 11042**

Please contact Member Services 1-866-586-8044 for additional information (TTY users 1-800-662-1220). You can call us 7 days a week from 8:00 am to 8:00 pm Eastern Time. We provide free language translation and interpretation for those who communicate in languages other than English.

AgeWell New York, LLC is a Health Maintenance Organization (HMO) plan with a Medicare contract. AgeWell New York, LLC has a Coordination of Benefits Agreement with New York State Department of Health, and a New York State Medicaid contract for AgeWell New York Advantage Plus (HMO SNP). Enrollment in AgeWell New York, LLC depends on contract renewal. ATTENTION: If you do not speak English, language assistance services are available to you free of charge. Call **1-866-237-3210 (TTY/TDD: 1-800-662-1220)**. ATENCIÓN: si no hablas inglés, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-866-237-3210 (TTY/TDD: 1-800-662-1220)**. Assistance services for other languages are also available free of charge at the number above.

**Notice of Nondiscrimination**

AgeWell New York complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. AgeWell New York does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. AgeWell New York provides free aids and services to people with disabilities to communicate effectively with us, such as:

Qualified sign language interpreters
Written information in other formats (large print, audio, accessible electronic formats, other formats)
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 AgeWell New York Member Services at **1-866-237-3210**. If you believe that AgeWell New York 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 with:

AgeWell New York
**Civil Rights Coordination Unit**
1991 Marcus Avenue Suite M201 Lake Success, New York 11042-2057
1**-866-237-3210**
**TTY/TDD: 1-800-662-1220**
Fax: 1-855-895-0778
Email: civilrightsunit@agewellnewyork.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordination Unit 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, TTY/TDD: 1-800-537-7697**. Complaint forms are available at **http://www.hhs.gov/ocr/office/file/index.html**.