



# MEMBER REIMBURSEMENT MEDICAL CLAIM FORM - HELP SHEET / FAQs

Question	Answer
What is this form used for?	This form is used to ask for payment for eligible Medical care you have already received. This form should not be used for Vision, Dental or Pharmacy services.
What is my responsibility?	Copayments, deductibles, coinsurance, and non-covered services will be patient responsibility. If you receive care from an out-of-network provider and the provider bills more than the Usual, Reasonable, and Customary charge, the member will be responsible (i.e. balance billed) for the sum of the co-insurance amount and any amount that is over the Usual, Reasonable and Customary charge. <b>THIS IS NOT A GUARANTEE OF PAYMENT.</b> Actual payment for covered service will be paid at the appropriate level according to your plan benefits and you may be billed for the difference between Ambetter Health's allowed amount and the providers billed charges.
What if my service was completed out of the service area?	If you were temporarily out of the service area and had a medical or behavioral health emergency, be sure to report your emergency to us within one (1) business day. Depending on your plan type, copayments may apply for emergency care received in an emergency room. Routine or maintenance care is not covered outside the service area and <u>will not</u> be reimbursed unless pre-arranged with Ambetter prior to receiving services.
What happens next?	After processing your claims, you will receive an Explanations of Benefits (EOB). The EOB explains the charges applied to your deductible (the fixed dollar amount you pay for covered services before the insurer starts to make payments) and any charges you may owe the provider. Please keep your EOB on file in case you need it in the future. You may also refer to your member handbook on AmbetterHealth.com.
Did you know?	You receive a higher benefit if you use an Ambetter Health provider. This can be especially cost effective when receiving ongoing services like therapy services or when purchasing durable medical equipment.
Who should I contact if I need help with completing this form?	Contact Member Services at 1-855-650-3789 (TTY 711)
Field Name	Description
Subscriber Information	Subscriber is the person: Who enrolls in an Ambetter from Home State Health and signs the membership application form on behalf of him/ herself and any dependents. In whose name the premium is paid.
Patient's Ambetter Member ID#	ID# with suffix, found on the front of the Ambetter from Home State Health Member ID card.
Patient's Name	Last and First names and Middle Initial of patient who received services.
Patient's Date of Birth	Date of birth: month (2 digits), day (2 digits), year (4 digits). Include newborn's date of birth in the same box as the parent's.
Provider's Name, Address, Telephone Number, Provider Federal Tax ID #:	A provider includes, but is not limited to, hospitals, physicians, optometrists, psychiatrists, licensed clinical social workers, durable medical equipment suppliers.
In what setting did the patient receive treatment?	Such as office, emergency room, outpatient hospital (for X-rays, tests), inpatient hospital, clinic, medical supply store.
If services were rendered outside of the U.S.	If applicable, indicate in what country services were provided, in what language (if not English) the bill and proof of payment written, and in what currency the bill was paid.
Diagnosis: What was the patient seen for?	Provide a diagnosis code and detailed description of illness or injury. (e.g., flu, broken leg, manic-depressive disorder, asthma)
Date(s) of Service	The date(s) the services were provided to the patient.
Procedures, Services, or Supplies Provided	Provide a procedure code and detailed description. (e.g., x-ray, office visit, lab work, leg cast, etc.)
Total Amount Paid	Total amount for which you are requesting reimbursement.
Proof of Service(s)	A document that demonstrates the service was actually rendered, listing date(s) of service, service(s) provided, and dollar amounts paid.
Proof of Payment	A document that demonstrates payment made by the member was received by the provider of service. Examples include: 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; a statement from the provider, on the provider's letterhead with authorized signature, indicating payment was made; a receipt for purchased items, with the provider's name and address preprinted on the receipt, with items listed and amount paid.

**Please submit this form and all documentation to:**

Ambetter from Home State Health • Claims Department-Member Reimbursement • P.O. Box 5010 • Farmington, MO 63640-5010