REIMBURSEMENT FORM

Please use this form to request reimbursement for any Out-of-Pocket expenses that would normally be covered by Ochsner Health Plan.

REASON FOR REIMBURSEMENT:

☐ Did not have access to or use my Medical ID Card at the time of service

☐ Traveled out of the country

☐ Visited a non-participating provider (Please provide details in the Explanation area.)

☐ Have primary coverage with another insurance carrier (Please include your Explanation of Benefits (EOB) or the denial letter from your primary insurance carrier).

☐ Other Explanation: _____

_____

_____

MEMBER INFORMATION:

Member Name: _____

Member Mailing Address: _____

_____

Member I.D._____

Daytime Phone: _____

Gender: ☐ Male ☐ Female

Member Date of Birth:

Month _____ Day _____ Year_____

I am the: ☐ Member

☐ Member Representative

MEMBER CERITIFICATION:

I represent that the Member information entered on this form is correct, that the Member named is eligible for the benefits and that the Member has received the service described. I also represent that the treatment received is not for treatment of an on-the-job injury. I also authorize release of all information pertaining to this claim to the plan administrator or its designees. Any person who knowingly and with intent to defraud Medicare, any insurance company or other person: (1) files an application for insurance or statement of claim containing any materially false information; or (2) conceals for the purpose of misleading, information concerning any material fact thereto, commits a fraudulent insurance act which is a crime.

Member Signature: _____ Date: _____

Member Representative (if applicable): _____ Date: _____

MEDICAL CLAIM INFORMATION (Complete applicable information*):

Date of Service: _____ Amount Requested: $_____

Description of Service: _____

_____

Provider's Name: _____ Provider's Phone: _____

Provider's Address: _____

_____

_____

Mail this completed form and your original receipts and itemized bills to the medical claims address on your Ochsner Health Plan member ID card or use the address below. Be sure to keep a copy for your records.

Ochsner Health Plans Claims
P.O. Box 4318
Scranton, PA 18505

*** Please include the receipt or bill to support the above service(s) provided, including dates of service, diagnosis codes and provider information (if available).**