Member Reimbursement Form

(Please complete all sections and retain a copy of all receipts and documents for your records)

TUFTS Health Plan
No one does more to keep you healthy.

Member Information

Member Name **Member Date of Birth** / /

Member 11 digit ID Number
(found on your THP ID card)

Treatment Information

Where were you seen? (Please select one)

- ❑ Emergency Room
- ❑ Physician's Office
- ❑ Other (Please specify) _____

What were you seen for? (e.g., Asthma) (Please write a brief description below)

All Dates of Service (specify below all dates on which you were seen)

What country were you seen in?
(for international claims only)

Payment Information

Proof of Payment (Please check one and include an itemized bill and one proof of payment)

- ❑ The front and back of a check written to the provider or the bank encoded front of a check
- ❑ A credit card statement or receipts
- ❑ A receipt that shows what was purchased and the amount that was paid

NOTE: An itemized medical bill indicating a zero balance signed by the provider or an authorized provider office representative is required (balance due statements are not considered itemized bills).

Additional Required Information

- ❑ For bills related to students attending college who received treatment from a college infirmary, a bursar bill is required
- ❑ For childbirth classes, proof of enrollment including start and end dates is required (e.g., copy of registration form, certificate of completion or a letter from the provider)

Is the member's condition related to:

- ❑ Employment (current or previous)
- ❑ Auto Accident (if yes, the state it occurred in) _____
- ❑ Other accident

Is there another health benefit plan?

- ❑ No
- ❑ Yes (If yes, fill out lines below)

Other insurance name _____

Other insurance policy number _____

Please submit this form and all documentation to:

TUFTS HEALTH PLAN
MEMBER REIMBURSEMENT CLAIMS, PO BOX 9191
WATERTOWN, MA 02471-9191

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