**MEMBER REIMBURSEMENT FORM**

1. **Member Name:**

2. **Member ID #:**

3. **Name of Provider of Service:**

4. **Telephone Number and Address of Provider (if known):**

5. **Date(s) of Service:**

6. **In what setting did you receive treatment?** *(e.g.: office, ER, hospital, clinic, etc)*

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**Use reverse side or another sheet of paper to include any additional information if necessary.**

7. **Are you responsible for any co-payments, coinsurance, or deductibles for this service?**
   - No____
   - Yes _____
   - Not Sure ____

   **Note:** Any reimbursement made will be less applicable co-payments, coinsurance, or deductible.

8. **Amount of reimbursement you are requesting. $**

9. **If services were performed outside the USA:**
   - In what country were services performed? __________________________________________
   - In what language was the bill/receipt written? _______________________________________
   - In what currency was the bill paid? ________________________________________________

10. **What were you seen for?** *(e.g.: flu, broken leg, asthma, etc.)*

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11. **Describe the services that were provided to you.** *(e.g.: lab work, ER visit, flu shot, etc.)*

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12. **Please include Proof of Payment AND Itemized Receipt**

   **Circle which of the following acceptable proof of payment you are attaching to this form.**
   - A copy of 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 with itemized bill and authorization if applicable.
   - 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 the amount paid. *Prescription required for Durable Medical Equipment purchase.

13. **Signature is required**

   I attest that the above information is accurate and complete. ________________________________

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**INTERNAL USE ONLY**

- **Claim #:** __________________
- **Claims Status:** ______
- **Provider #:** __________________
- **Post Cataract Eyewear Procedure Codes**

**NOTE:** Do not use this form for Weight Watchers or Fitness reimbursement. For Weight Watchers
reimbursement, use the Tufts Medicare Preferred Member Attendance Tracker form. For Fitness use the
Fitness Reimbursement form.

**Tufts Health Plan Medicare Preferred**

**Customer Relations**

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