Member Reimbursement Form Instructions

To make sure you are giving us all the information we need to make a decision, you can fill out the Member Reimbursement Form to make your request for payment. Please note that is not required to complete the Member Reimbursement form but it will help us process the information faster.

- The following information must be attached to this form or included with your request for payment. However, HealthSun Health Plans may request additional documentation when necessary.
    - Copies of itemized statement from provider that show dates of service, place of service, diagnosis codes, procedure codes, units/days, and amount charged.
    - Copy of receipt with the provider's name and address preprinted.
    - Proof of payment that includes but is not limited to bank statements, front and back of cleared check written to provider, etc.
    - Copies of medical records supporting the services received.

- If the request is submitted by someone other than the member, he or she must submit a copy of the papers showing appointment as legal representative, such as a completed Appointment of Representative, Power of Attorney, Court Appointed Guardian or any other proof of legal representation. You can download a copy of the Appointment of Representative form at our website by accessing the following link https://www.healthsun.com/members/Grievances. If a person claims payment as the legal representative of a deceased member's estate, he or she must submit copy of the papers showing appointment, such as Executor of an Estate, Social Security Administration Survivor Benefits Eligibility letter or any other proof of legal representation.
- Members who received emergency care outside of the United States should follow up immediately with their Primary Care Physician. For further assistance, please contact Member Services department.
- Medical bills paid in a currency other than U.S. Dollar will be converted using the currency exchange rate for the country where services were rendered and the date the payment was made.
- After the form or request for payment is completed and supporting documentation is collected, please send all documents to the Claims Department at the address, email or fax listed below within **one (1) year** of the date of service. If you are unable to submit this form or request for payment and the additional documentation requested within the allowable timeframe; you must provide a letter of good cause for the delay.

Attention: Claims Department
9250 W Flagler Street, Suite 600, Miami, FL 33174
Fax number: (786) 623-6655 – Email: claimsdept_efax@healthsun.com

Any person who knowingly and with intent to injure, defraud, or deceive any insurer, files a statement of claim or an application containing any false or misleading information may be found guilty of a felony of the third degree.

Member Reimbursement Form

ONE FORM PER MEMBER/PER PROVIDER
Please print clearly, complete all sections and sign. Retain copy for personal records.

Member Information				
Member Name:		**Date of Birth:**		
Primary Care Physician:		**Member ID:**		
Address:		**City:**	**State:**	**ZIP:**
Day Phone:	**Evening Phone:**	**Requestor:** ☐ **Member** ☐ **Member's Representative**		

Provider/Billing Information
Provider Name:
Provider Address:
Provider Phone:
Provider Tax ID#:

Additional information: Complete any information that applies.		
1. Was the above service(s) received because of an emergency?	☐ YES	☐ NO
2. Was the condition above related to an auto accident?	☐ YES	☐ NO
3. Were services above rendered out of the country?	☐ YES	☐ NO
4. Did any other insurance company pay for services received? (i.e. travel insurance)	☐ YES	☐ NO
5. Was your primary care physician notified?	☐ YES	☐ NO
6. Were you referred to the attending provider by your primary care physician?	☐ YES	☐ NO
7. Is a copy of itemized statement included with this form?	☐ YES	☐ NO
8. Is a copy of receipt included with this form?	☐ YES	☐ NO
9. Is proof of payment included with this form?	☐ YES	☐ NO
10. Are copies of medical records included with this form?	☐ YES	☐ NO

The following information must be obtained from your provider, or must be included on the itemized statement from your provider.						
Dates of Service	**Place of Service (Office, Emergency Room, Urgent, Hospital, Clinic, Ambulance, Home)**	**Diagnosis Code (DX)**	**Procedure Codes**	**Units/Days**	**Amount Charged in U.S. $**	**Amount Paid in U.S. $**
				Total:	**$**	**$**

If amount charged was originally in currency other than U.S. dollars, please indicate total charged amount below:	**If amount paid was originally in currency other than U.S. dollars, please indicate total paid amount below:**
$	**$**

HealthSun Health Plans complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. HealthSun does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-877-336-2069. (TTY: 1-877-206-0500). ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-877-336-2069. (TTY: 1877-206-0500). HealthSun Health Plans is an HMO plan with a Medicare contract. Enrollment in HealthSun Health Plans depends on contract renewal.

Please explain the circumstances regarding your reimbursement request. Attach additional sheets if necessary.

Where did these services take place? (City, State and Country)

If services were rendered outside U.S. please specify your travel dates: ____/____/______ to ____/____/______

In detail, explain the nature of the incident/accident/injury/emergency:

I certify that the above information on this form, statements written above, and all attachments are correct, complete, accurate, and true to the best of my knowledge. I attest that the services were received and paid for in the amount requested as indicated above. I authorize the Provider to release appropriate information necessary to process this claim to plan provisions. Additionally, I have read and understood the fraud statement on the front of this form and acknowledge that if any information on this form is misleading or fraudulent, my coverage may be cancelled and I may be subject to criminal and/or civil penalties for false health care claims.

Print Name	Signature	Date

For questions regarding this form or any assistance, you may need, please contact our Member Services Department at 1-877-336-2069. TTY users should call 1-877-206-0500. Hours during October 1st through March 31st are seven days a week from 8am to 8pm (we are closed on Thanksgiving and Christmas Day). From April 1st until September 30th we are available Monday through Friday from 8am to 8pm (our office will be closed on federal holidays).