Reimbursement Submission Form

SECTION A

Membership Information

MEMBER'S FULL NAME

MEMBER ID#

DATE OF BIRTH

Reimbursements are applicable to Eligible Medical Needs only and are subject to all Member Responsibility Amounts (MRAs).

Member reimbursements must be submitted within 180 days from the date of service.

* If your medical needs arise from an accident, injury or emergency room visit, we may ask you to submit a Needs Processing Form (NPF) and/or associated medical records to determine eligibility.

** We recommend that you obtain an Advance Opinion for eligibility prior to the date of service, if possible.

*** HealthCare Credits are only available on certain memberships, if you are unsure, please contact us at: 1.833.3-ALTRUA (258782)

Submit Forms To (one of the following):

Online: https://altruahealthshare.org

Email: memberforms@altruahealthshare.org

Fax : 512.382.5520

Mail : PO Box 90849 - Austin, TX 78709-0849

NOTE Reimbursements may take up to 30-45 calendar days to process once all required information has been received.

SECTION B

Reimbursement Information

Please indicate the service for which you are requesting reimbursement.

- ◯ Office Visit
  Includes office visit costs, common tests, and immunizations
- ◯ Service-Specific Costs
  Includes outpatient therapy, X-ray, and laboratory services
- ◯ Emergency Room Visit*
  Includes costs associated with physicians and facilities
- ◯ Advance Opinion for Eligibility **
  Includes diagnostic services, advanced imaging, surgery, and in-office procedures
  ADVANCE OPINION FOR ELIGIBILITY #
- ◯ Other
  PLEASE DESCRIBE

NOTE: Prescriptions and durable medical equipment (DME) are not eligible for reimbursement.

SECTION C

Reimbursement Method

Please specify how to issue reimbursement.

◯ Direct Check ◯ HealthCare Credit***

SECTION D

Reimbursement Required Documents

The following must be submitted to be considered for reimbursement.

1. This completed Reimbursement Submission Form
2. Proof of payment
3. Itemized statement or "superbill" from the provider that includes the following:

-Provider Name
-Date of Service
-Procedure Codes (CPT, HCPC, Rev. Codes)
-Provider Tax ID
-Diagnoses Code (ICD-10)
-Method of payment (cash, credit, or check)

SIGNATURE

PRIMARY CONTACT NAME DATE

QUESTIONS: Call Member Services @ 1.833.325.8782

Caring for One Another