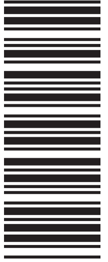
Member Reimbursement Claim Form



This form may be used for Allwell Medicare products.

Important: Complete a separate Member Reimbursement Claim Form for each member asking for reimbursement for covered services and for each doctor and/or facility.

To avoid processing delays, please include the following information with this form:

- Copy of bill showing all services received. Must include name, address and phone number of doctor and/or facility.
- Proof of payment.[1] (Keep a copy of all receipts and documents for your records.)

Mail all medical claims to:
Allwell Medicare Claims
PO Box 3060
Farmington, MO 63640-3822

or

Mail all behavioral health claims to:
(Arizona Only)
MHN Claims Department
PO Box 14621
Lexington, KY 40512-4621

Any missing information may cause a delay in processing your request.

Section 1: Member information – Please complete a separate form for each person who received services:

Last name

First name

Middle initial

Member ID #

Birth date

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Home phone number

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Email address

Address

City

State

ZIP code

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[1]"Proof of Payment" includes, but is not limited to: a copy of the credit card charge slip, a cruise ship statement, canceled checks, a bank account statement, cash withdraw slips, or anything else that shows dates that match the medical service date. A valid receipt or doctor's statement is also acceptable if it shows the amount the member paid.

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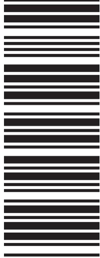
Section 2: Other insurance – Complete if it applies.



Is the member also covered by other medical insurance at this time?

☐ Yes *(Complete information below.)* ☐ No

Name of insurance company

Policy #

Subscriber/Member ID #

Does this member have Medicare coverage?

☐ Yes ☐ No

Section 3: Services received – If services received outside the U.S., please also complete Section 4.

Name of doctor and/or facility

Phone number of doctor and/or facility

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Address of doctor and/or facility

City

State

ZIP code

Medical description or nature of illness or injury

Amount requested to be reimbursed

Medical information authorization and release

I hereby authorize any physician, health care practitioner, hospital, clinic, or other medically related facility (as listed above) to furnish to Allwell, its agents, designees, or representatives any and all information pertaining to medical treatment for purposes of reviewing, investigating or evaluating applications or claims. I also authorize Allwell, its agents, designees, or representatives to disclose to a hospital or health care service plan, insurer or self-insurer any such medical information obtained if such disclosure is necessary to allow the processing of any claim. If my coverage is under a Group Benefit Agreement held by my employer, an association, trust fund, union, or similar entity, this authorization also permits disclosure to them to the extent necessary for utilization review or financial audit purposes. This authorization shall become effective immediately and shall remain in effect as long as Allwell is asked to process claims under my coverage. A photostatic copy of this authorization shall be considered as effective and valid as the original. I hereby certify that the above statements are correct.

Name of person completing form (please print)

Signature

Date

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Relationship – description of authority to act on behalf of the member, if applicable

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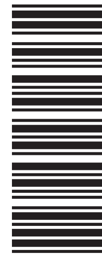
Section 4: Foreign claims questionnaire



If you received health care services while traveling outside of the United States, or on a cruise in foreign or domestic waters, you'll need to complete this section. Be sure to answer every question so your claim can be processed quickly. Please provide all available documents for services received.

What dates were you traveling out of the country?

What was the nature of your emergency resulting in medical treatment?

How long were you ill before you received medical attention?

Were you admitted into the hospital?

☐ Yes ☐ No

If treated as an outpatient, how many times did you see the doctor?

Name of the hospital, clinic or doctor's office where you received treatment

Dates of admission

Address

City

ZIP code

Country

Phone number

Name of treating physician

Phone number

Did you receive diagnostic tests?

☐ Yes ☐ No

If "Yes," what type?

Were surgical procedures performed?

☐ Yes ☐ No

If "Yes," what type?

Was your primary doctor in the U.S. notified?

☐ Yes ☐ No

If "Yes," when?

Note: Only covered benefits or those deemed medically necessary will be considered for reimbursement.

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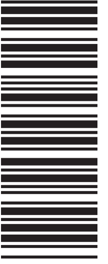

Any person who knowingly presents a false or fraudulent claim for the payment of a loss may be guilty of a crime, and may be subject to criminal and civil penalties.

Allwell has a contract with Medicare to offer HMO, PPO and HMO SNP plans. Allwell has a contract with Medicare and the state Medicaid program to offer HMO SNP plans. Enrollment in Allwell depends on contract renewal.

Section 1557 Non-Discrimination Language
Notice of Non-Discrimination

Allwell complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Allwell does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Allwell:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, accessible electronic formats, other formats).
- Provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages.

If you need these services, contact Allwell's Member Services at: 1-800-977-7522 (HMO and HMO SNP) (TTY: 711). From October 1 to February 14, you can call us 7 days a week from 8 a.m. to 8 p.m. From February 15 to September 30, you can call us Monday through Friday from 8 a.m. to 8 p.m. A messaging system is used after hours, weekends, and on federal holidays.

If you believe that Allwell has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance by calling the number above and telling them you need help filing a grievance; Allwell's Member Services is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019 (TDD: 1-800-537-7697).

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

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SPANISH	ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-977-7522 (HMO and HMO SNP) (TTY: 711).
NAVAJO	SHOO KWE'É: Diné bizaad bee yáníłti'go, saad bee 'áka'e'eyeed bee 'áka'anída'awo', t'áá jíík'eh, nihá hólǫ́. kohjį' biniiyá holne' dooleeł 1-800-977-7522 (HMO and HMO SNP) (TTY: 711).
CHINESE	注意：如果您說中文，您可以免費獲得語言援助服務。請致電 1-800-977-7522 (HMO and HMO SNP) (TTY: 711)。
VIETNAMESE	CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-977-7522 (HMO and HMO SNP) (TTY: 711).
ARABIC	تنبيه: إذا كنت تتحدث العربية، فإن خدمات المساعدة اللغوية المجانية متاحة لك. يُرجى الاتصال بالرقم. 1-800-977-7522 (HMO and HMO SNP) (مكبلاو مصلا فتاه مقر: 711).
TAGALOG	PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-977-7522 (HMO and HMO SNP) (TTY: 711).
KOREAN	주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-977-7522 (HMO and HMO SNP) (TTY: 711) 번으로 전화해 주십시오.
FRENCH	ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-977-7522 (HMO and HMO SNP) (TTY: 711).
GERMAN	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-977-7522 (HMO and HMO SNP) (TTY: 711).
RUSSIAN	Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-977-7522 (HMO and HMO SNP) (TTY: 711).
JAPANESE	注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-977-7522 (HMO and HMO SNP) (TTY: 711) まで、お電話にてご連絡ください。
PERSIAN	توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-800-977-7522 (HMO and HMO SNP) (TTY: 711) تماس بگیرید.
SYRIAC	ܙܘܗܪܐ: ܐܢ ܡܡܠܠܝܬܘܢ ܣܘܪܝܬ، ܒܚܠܡܬܘܬܐ ܕܗܝܪܬܐ ܕܠܫܢܐ، ܡܓܢܐܝܬ، ܐܝܬ ܦܬܝܚܐ ܬܠܘܟܘܢ. ܩܪܘܒܘܢ ܡܢܘܢ 1-800-977-7522 (HMO and HMO SNP) (TTY: 711)
SERBOCROATIAN	OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-800-977-7522 (HMO and HMO SNP) (TTY: 711).
THAI	เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-800-977-7522 (HMO and HMO SNP) (TTY: 711).