GlobalHealth

210 Park Ave. | Suite 2800 | Oklahoma City, OK 73102-5621

Direct Member Reimbursement Form Instructions

What is this form used for?
Please use this form if you are a GlobalHealth Generations Medicare Advantage Plan's member and you pay full cost out-of-pocket for a covered service listed in your Evidence of Coverage. Please refer to your Evidence of Coverage for a full list of covered services and for instances when you can ask us to pay our share of a bill you have received for covered medical services or Part B drugs. If you get the services at any of our In-Network provider locations, the provider of services will directly bill GlobalHealth.

How to request benefits?

Step 1: Complete all areas of the claim form before returning the claim to us. Please collect and submit as much information you can to avoid any delays in processing your request. Use a separate form for each claim.

If GlobalHealth or Generations is your secondary insurance carrier, please attach your primary Explanation of Benefits (EOB) to this form.

Step 2: Include any supporting documents to support your request, including but not limited to:

- Itemized bill you received from your doctor.
- Any receipts of services.
- Diagnosis or Procedure codes.
- Proof of payment

Step 3: Sign and date the claim form.

Step 4: Recheck **all** information and make a copy of this submission.

Step 5: Submit this form along with a copy of your itemized bill to:
GlobalHealth, Inc.
Attn: Claims Department
P.O. Box 1747
Oklahoma City, OK 73101-1747

What are the next steps?

When we receive your request for payment, we will let you know if we need any additional information from you. Otherwise, we will consider your request and make a coverage decision. If we decide that the medical care is not covered, or you did not follow all the rules, we will not pay for our share of the cost. You will receive detailed Explanation of Benefits (EOB) explaining the outcome of your claim within 60 days from the date the plan receives this form. You may also refer to your Evidence of Coverage for your appeal rights.

Have any questions or need help submitting this form? Give us a call at the Member services number listed on your ID card.

Direct Member Reimbursement Form

Please refer to your Evidence of Coverage Handbook for your covered services. Please send the receipt(s) or Itemized bill and any supporting documents with this form. Make a copy of your claim submission for your records and allow 60 days to process your request. Cash register and credit card receipts alone are not acceptable as proof of purchase. Forms without the required information will not be processed. All requests must meet the Plan's coverage and eligibility requirements to be reimbursed.

Who is making this request? Member ☐ Appointed Representative ☐

Appointed Representatives: Please include a signed Appointment of Representative form (CMS1696) or equivalent notice. You can request a copy of the AOR form by calling the Member services.

SECTION 1 – PATIENT INFORMATION

Patient's Name as shown on your ID card:			
Date of Birth (mm/dd/yyyy): / /		Member ID Number:	
Street Address (include Apartment Number):			
City:	State:	Zip Code:	Telephone:

SECTION 2 – REASON FOR REQUEST (Your reason for submitting this claim)

☐Supplemental Eyewear (1 Pair of glasses or contacts per year)
☐Eyewear after Cataract surgery
☐Emergency Services (Please describe)
☐Other: _____

SECTION 3 – PROVIDER OF SERVICE (Please provide as much information as you can. You may need to ask.)

Facility or Provider Name:			
NPI # (If Known)		Tax Id Number (If Known):	
Provider Address:			
City:	State:	Zip Code:	Telephone (Include Area Code):

SECTION 4 – INFORMATION ABOUT SERVICES FURNISHED

Date of Service:	
Service Codes (Diagnosis, CPT or HCPCS Codes, if known):	
Service Description:	
Charge of Service:	Amount paid:

SECTION 5 – INFORMATION ABOUT HEALTH INSURANCE OTHER THAN GLOBALHEALTH.

Is this patient covered by another group health plan? ☐ Yes ☐ No (If yes, complete the following)
Are you covered under your spouse's employee group health plan? ☐ Yes ☐ No (If yes, complete the following)
If you answered 'Yes' in any of the above questions or if you have other medical insurance, other than GlobalHealth, please complete:
Another Group Health Plan's Name and Insured ID #:

I authorize GlobalHealth to request a medical claim or any supporting documentation from the provider of services. I authorize provider to release any information needed for this request to GlobalHealth Inc.

Signature of Patient:	**Date Signed:**