GlobalHealth

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

Direct Member Reimbursement Form Instructions

Patient's Request for Medical Payment

What is this form used for?

This form is to be used by GlobalHealth and Generations members to be reimbursed for payment(s) made by the member directly to out-of-network providers. If using an in-network provider, they will bill on your behalf, then bill you for the portion of the benefit that is not covered or reimbursable by the plan.

Please follow these steps to ensure faster claim processing:

PLEASE TYPE OR PRINT THE INFORMATION. If printing on the form, please do so in blue or black ink. Please print legibly and clearly. Complete all the required fields on the form. 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.

Mail the completed claim form, along with a copy of the Superbill or Invoice from the provider's office and any receipts of your payment to:

GlobalHealth
Attn: Claims
PO Box 2328
Oklahoma City, OK 73101

If using a non-contracted provider who is not willing to submit a claim on your behalf, please request a Superbill or Invoice that contains the following information:

This information is required in order to process a claim.

- ✓ Patient Name and Member Number.
- ✓ ICD10 Diagnosis Code(s) related to claim.
- ✓ Procedure Codes (HCPC, CPT) – with any necessary modifiers.
- ✓ Billed amount for each Procedure Code.
- ✓ Amount paid by the member for each Procedure Code.
- ✓ Place of Service code.
- ✓ Provider's name and tax identification number.

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How to maximize your benefit:

Using an in-network provider will provide the maximum benefit.

Added eye care benefit:

Glasses after cataract surgery: No maximum benefit allowance. Generations will cover the same costs for services reimbursable by Original Medicare.

Supplemental glasses: Maximum benefit allowance of $200

What are the next steps?

After your completed form and attachments are received and processed, we will send you an Explanation of Benefits (EOB) explaining the outcome of your claim within 45 days from the date of the plan receives this form. The EOB will explain the charges, amount payable by your plan, and any charges you may owe the provider of the services rendered related to the claim on this form.

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Beneficiary Name as it appears on your Health Insurance Card	
Member Identification Number as it appears on your Health Insurance Card	**Patient's Sex** ☐ Female ☐ Male
Patient's Mailing Address (City, State, Zip Code) _____ (Street or PO Box – Include Apartment Number, if applicable) _____ (City) (State) (Zip)	
Patient's Telephone Number (please include Area Code) _____	

1. Are you employed and/or covered under an employee health plan? _____ Yes _____ No

2. Is your spouse employed and are you covered under your spouse's employee health plan?
   _____ Yes _____ No

3. If you have other medical insurance coverage, other than GlobalHealth or Generations, please complete:

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a. Name and Address of other insurance:

b. Policyholder's Name and Number:

Name:
Number:

I AUTHORIZE ANY PROVIDER'S OFFICE OR HEALTH INSURANCE COMPANY TO RELEASE ANY INFORMATION NEEDED FOR THIS MEDICAL CLAIM TO GLOBALHEALTH GENERATIONS. I PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL, AND AM REQUESTING PAYMENT OF THESE EYE CARE MEDICAL BENEFITS TO ME.

Signature of Patient	**Date Signed**

Please attach any payment receipts made by the patient/beneficiary and all Superbills or Invoices to this form.

GlobalHealth complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-844-280-5555 (TTY: 711).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-844-280-5555 (TTY: 711)