Direct Member Reimbursement Request

Please fill out section 1 of this form and ask your provider to help you in filling out section 2 and section 3 on the back page. Once the form is complete, please submit it to MediGold at the address listed below, along with your itemized bill, a copy of your paid receipt and a copy of the prescription for your eyeglasses (if applicable). A complete description of reimbursement coverage is provided in your *Evidence of Coverage*.

1. Member Information and Signature

By submitting this claim form, you are requesting reimbursement from MediGold. I certify that I have incurred these expenses and have proof of payment.

Are you the ☐ Member or ☐ Member Representative? **Please check one box**.

Member Name	**Member ID #**
Address	
City/State	**Zip**
Signature*	**Date**

* *If the individual cannot sign, a person who is authorized to do so under state law in the state where the individual resides must sign above. This signature certifies that the person signing is authorized under state law to complete this form and that all documentation of this authority is available upon request by the plan as outlined by Centers for Medicare & Medicaid Service, the federal agency that runs Medicare. To appoint someone to represent you on this type of matter, please complete a CMS Appointment of Representative form found here on the MediGold website: https://medigold.com/ Members/Resources/Forms.*

Please mail this reimbursement request to:

MediGold Member Reimbursement
6150 East Broad Street, Suite EE320
Columbus, Ohio 43213-1574

Don't forget to include:

_____your itemized bill;
_____a copy of your paid receipt;
_____a copy of the prescription for your eyeglasses (if applicable).

Notice: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

Attention Provider: Please assist our MediGold member in the completion of section 2 and section 3 of this form.

2. Description of Services

Date of Service	Place of Service	HCPCS Procedure Code	Description of Services	ICD-10	Units	Billed Amount
						$
						$
						$
						$
						$

Amount Paid by MediGold Member $ ________________

3. Provider Certification/Verification

I certify that this patient incurred the expenses listed on this form.

Provider Name

Provider NPI# **Provider TIN**

Address

Participating Medicare provider? **Yes** **No**

Cataract Surgery? **Yes** **No** **Cataract extraction date __/__/__** **Diagnosis**

Provider Signature **Date**

If you have any questions, please contact MediGold Member Services at 1-800-240-3851 (TTY 711), 8 a.m. – 8 p.m., 7 days a week.

For transplant related services, please complete this form for consideration of reimbursement.

In this section, please list your lodging expenses by date for the member and **applicable companion or caregiver**.

Please note that the receipt for lodging items documented below must be included with this form. **Items not eligible for reimbursement are listed on page 3.**

Lodging Receipts*
Reimbursement based on receipts for sleeping accommodations for those listed in Section 1 of this form, including tax and tip.

Date(s)	Name of Hotel or Motel	Number of People	Total Dollar Amount for Reimbursable Lodging

Mileage

Please include addresses from the patient's home to the transplant facility. (Mileage is reimbursed at most current medical mileage rate at www.IRS.gov and based on MapQuest results.) Gasoline receipts are not required.

Member Home Address	Transplant Facility Address
Date(s) Traveled from Home to Facility	**Date(s) traveled from Facility to Home**

Date(s)	Parking Fees (Hotel/Motel or Transplant Facility Specific if applicable)

Miscellaneous

Please list miscellaneous services or expenses not already addressed in the above sections.

Please note: Reimbursement is considered for member and caregiver and based according to MediGold member benefits.

Date(s)	Name of Service or Expense(e.g., airline ticket)	Total Dollar Amount of Service or Expense

The following services, including and not limited to are excluded as part of this benefit:

- Food and alcohol
- Car rental
- Clothing
- Entertainment
- Expenses for persons other than the member's companion or caregiver
- Non-legible receipts
- Parking fees incurred other than at hotel/motel or hospital
- Personal hygiene items
- Valet
- Any service that is an additional charge to the room charge
- Any mileage that is not to or from the transplant facility
- Any other service not listed in this policy is excluded from reimbursement