Reimbursement request form

Completion guide

This form is for the reimbursement of any out-of-pocket expenses. Please be advised that missing information may result in the denial or delay of your request. Please do not highlight documentation, as highlighted sections become unreadable in our imaging software.

Step 1: Member information

- Complete required fields with member information and follow the steps below.

Step 2: Reimbursement information

- **Did you file online:** If a claim was filed online at arkbluecross.com/blueprint, mark "Y" for yes; if not, mark "N" for no.
- **Date(s) expense(s) incurred:** Provide the date or range of dates the expenses were incurred. **Please note:* *Date of Service must be within 90 days of filing date.*
- **Merchant/Provider name:** Provide the name of the provider or facility where the expense was incurred.
- **Name of person receiving product/service:** Provide your name for whom the service was provided or product purchased.
- **Claim amount:** Provide the total amount requested for the specified expense.
- **Total reimbursement requested:** Total the amounts in the "Claim Amount" boxes.

Step 3: Member certification

- Sign and date the form after reading the Member Certification.

Documentation requirements

Documentation for expenses includes a third-party receipt containing the following information:

- Date service was received or purchase was made
- Description of service or item purchased
- Dollar amount (after insurance, if applicable)

Unacceptable forms of documentation include the following:

- Provider statements that only indicate the amount paid, balance forward, or previous balance
- Credit card receipts that only reflect a payment
- Bills for prepaid medical expenses where services have not yet occurred

When submitting a receipt for a co-payment amount, please be sure the co-payment description is on the receipt. In some cases, you will need to ask for a receipt at the point of service. If "co-payment" is not clearly identified, have the provider write "co-payment" on the receipt and sign it.

Instructions

1. Complete all sections of this form.
2. Securely email, mail, or fax the completed form to:
   Secure Email: abcbs@healthaccountservices.com
   Address: PO Box 3063 Fargo, ND 58108-3063
   Fax: 833-507-1077
3. If you have any questions about completing this form, please contact Arkansas Blue Medicare Customer Service at (877) 743-9481. We have representatives available Monday-Friday, 7:00 am to 7:00 pm Central.

Step 1: Member information

First name	**MI**	**Last name**

Member ID	**Birth date** (mm/dd/yyyy)	**Phone**

Street or PO box	**City**	**State**	**ZIP**

Email (optional)

Step 2: Reimbursement information

Claim Information

Did you file online? (Y or N)	Date(s) expense(s) incurred	Merchant/Provider name	Name of person receiving product/service	Claim amount
				$
				$
				$

Total request =

Step 3: Member certification

In filing this claim, I understand that I should retain copies of original receipts. False receipts and alterations to original receipts may result in civil or criminal prosecution. Submitting a claim does not guarantee reimbursement. Eligible expenses are determined based on the terms and conditions of the Medicare Advantage plan. Review the plan's evidence of coverage for a description of plan benefits, exclusions, limitations, and conditions of coverage. I understand that Arkansas Blue Medicare, including its agents or employees, will not be held liable if I submit ineligible expenses for reimbursement. I certify that the reimbursement is for the purpose of a qualified expenditure for an eligible individual. By submitting this request, I certify that the information provided is complete and accurate. If there are any changes in the provided information, I understand it is my responsibility to notify Arkansas Blue Medicare. I acknowledge that this form may be electronically signed, and I agree that the electronic signature(s) appearing on this document are the same as handwritten signatures for the purpose of validity, enforceability, and admissibility.

Member Signature	**Date**