Medical Reimbursement form

Use separate form for each patient and provider

General instructions: Make sure this form is filled out completely to receive timely reimbursement for paid medical services according to plan benefits. No reimbursement will be sent if any information or receipts are not provided upon filing of this form. Once this form is completed, send it to Indiana University Health Plans, PO Box 11196, Portland, ME, 04101-7196.

Requests for reimbursement must be submitted within 365 days from date of service.

- Print requested information.
- Include itemized and legible copies of receipts, which must match information documented in this form. Please note, items associated with non-legible receipts will not be reimbursed. Receipts will not be returned.
- Receipts must show payment to the healthcare provider listed on this form. Receipts can be items such as an itemized receipt from a healthcare provider or a credit card receipt with the provider name referenced.
- Do not submit a form if your physician or other healthcare professional is within the provider network or if they are also filing a claim to IU Health Plans for the same service.

Patient information

Member name (print):		
Member date of birth (MM/DD/YYYY):		
Relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other:		
Member ID#:	Group ID#:	
Subscriber street address:		
City:	State:	ZIP code:

Provider information

Provider name (print):		
Provider TIN:	Provider NPI:	
Provider street address:		
City:	State:	ZIP code:

Questions? Please call Customer Service at the number on the back of your ID card.

This form can also be completed and submitted electronically via our Member Portal.

(Complete both pages of this form.)

Health Plans

Medical Reimbursement form, continued

Patient information

Member name (print):	Member ID#:

Service information

Date (MM/DD/YYYY)	Place of service	Codes for service*	Description of service provided*	Diagnosis code	Charges
			Total charges for reimbursement:		

If service code is unknown, please provide a brief description of service provided.

Patient authorization

- I hereby authorize IU Health Plans to provide the information relating to medical services and treatment rendered to me and/or my dependents.
- I understand that the duration of the authorization is for the term of coverage of the policy or contract under which a claim for health benefits has been submitted. I understand that I have a right to receive a copy of this authorization upon request. I agree that a photographic copy of this authorization is as valid as the original.
- I have furnished the information on this form so that IU Health Plans may consider this claim. By signing below, I certify the information is correct and the expenses were incurred by the patient named above.
- Should there be an overpayment more than the amount payable under the Medical Plan, I agree to reimburse IU Health Plans to the extent of the overpayment.

Patient's authorized person's signature

Relationship of authorized person

Payment information

I authorize benefits to be paid to me. I understand it is my responsibility to pay the physician, hospital or provider of service.

Subscriber

Date

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Health Plans

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