meridiancomplete

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Member Reimbursement Form & Foreign Claim Questionnaire
MeridianComplete (Medicare – Medicaid Plan)

Important: Complete a separate form for each member asking for reimbursement for covered services and for each doctor and/or facility.

To avoid processing delays, please include the following information with this form:

- Copy of itemized bill showing all services received. Must include name, address, phone number, and tax ID number of doctor and/or facility and all diagnosis and procedure codes.
- Proof of payment.[1] (Keep a copy of all receipts and documents for your records.)
- See the instructions in Section 4 for Foreign Claim Questionnaire for services received outside of the U.S.
- If a member's representative completes this form, please fill out an Appointment of Representative (AOR) Form and attach it to the submission.

Mail all medical claims to:
MeridianComplete MMP Claims
P.O. Box 3060
Farmington, MO 63640-3822

Mail all behavioral health claims to:
MHN Claims department
P.O. Box 14621
Lexington, KY 40512-4621

Any missing information may cause a delay in processing your request.

Section 1: Member information –
Please complete a separate form for each person who received services:

Last name:	First name:	Middle initial:
Member ID:	Birth date (MM/DD/YYYY):	
Home phone number: ( )	Email:	
Address:		
City:	State:	ZIP code:

1"Proof of Payment" includes, but is not limited to: a copy of the credit card charge slip, a cruise ship statement, canceled checks, a bank account statement, cash withdraw slips, or anything else that shows dates that match the medical service date. A valid receipt or doctor's statement is also acceptable if it shows the amount the member paid.

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Section 2: Other insurance – Complete if it applies.

Is the member also covered by other medical insurance at this time? ☐ Yes (Complete information below.) ☐ No	
Name of insurance company:	Policy #:
Subscriber/Member ID:	Does this member have Medicare coverage? ☐ Yes ☐ No

Section 3: Services received – If services were received outside of the U.S., please skip to Section 4.

Name of doctor and/or facility:		Phone number of doctor and/or facility:
Name of insurance company:		Policy #:
Address of doctor and/or facility:		
City:	State:	ZIP code:
Date of service (MMDDYYYY):	Amount requested to be reimbursed:	
Medical description or nature of illness or injury:		

Medical information authorization and release

I hereby authorize any physician, health care practitioner, hospital, clinic, or other medically related facility (as listed above) to furnish to MeridianComplete, its agents, designees, or representatives any and all information pertaining to medical treatment for purposes of reviewing, investigating or evaluating applications or claims.

I also authorize MeridianComplete, its agents, designees, or representatives to disclose to a hospital or health care service plan, insurer or self-insurer any such medical information obtained if such disclosure is necessary to allow the processing of any claim. If my coverage is under a Group Benefit Agreement held by my employer, an association, trust fund, union, or similar entity, this authorization also permits disclosure to them to the extent necessary for utilization review or financial audit purposes. This authorization shall become effective immediately and shall remain in effect as long as MeridianComplete is asked to process claims

under my coverage. A photostatic copy of this authorization shall be considered as effective and valid as the original. I hereby certify that the above statements are correct.

Name of person completing form (please print):	Signature:
Date (MM/DD/YYYY):	Relationship – description of authority to act on behalf of the member, if applicable:

Section 4: Foreign claim questionnaire

If you received health care services while traveling outside of the United States, or on a cruise in foreign or domestic waters, you'll need to complete this section. Be sure to answer every question so your claim can be processed quickly. **Please provide all medical records given by the provider, such as a Face Sheet, Admission Sheet, Discharge paperwork, and any other paperwork provided, preferably in English. What dates were you traveling out of the country?**

What dates were you traveling out of the country?	
What was the nature of your emergency resulting in medical treatment?	
How long were you ill before you received medical attention?	
Were you admitted into the hospital? ☐ Yes ☐ No	If treated as an outpatient, how many times did you see the doctor?
Name of the hospital, clinic or doctor's office where you received treatment:	Date(s) of admission/service:
Address:	
City:	ZIP code:
Country:	Phone number:
Naming of treating physician:	Phone number:

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Section 4: Foreign claim questionnaire (cont.)

Amount requested to be reimbursed:	
Did you receive diagnostic tests? ☐ Yes ☐ No	If “Yes,” what type?
Were surgical procedures performed? ☐ Yes ☐ No	If “Yes” what type?
Was your primary doctor in the U.S. notified? ☐ Yes ☐ No	If “Yes” when?

Note: Only covered benefits or those deemed medically necessary will be considered for reimbursement.

MeridianComplete is a health plan that contracts with both Medicare and Michigan Medicaid to provide benefits of both programs to enrollees.

ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call MeridianComplete at <1-855-323-4578> (TTY users should call <711>)<8 a.m to 8 p.m., seven days a week.> On weekends and on state or federal holidays, you may be asked to leave a message. Your call will be returned within the next business day. The call is free.

You can also get this information for free in other formats, such as large print, braille, or audio. Call <1-855-323-4578> (TTY users should call 711), <8 a.m. to 8 p.m., seven days a week>. On weekends and on state or federal holidays, you may be asked to leave a message. Your call will be returned within the next business day.