Hometown Health Senior Care Plus

REIMBURSEMENT CLAIM FORM

WHAT IS THIS FORM FOR?

Use this Reimbursement Claim Form for direct reimbursement for services rendered for Urgent or Emergency Care. If you receive emergent medical care outside of the country, Senior Care Plus and Hometown Health will reimburse you (the member) the amount that we would pay the facilities and providers that treat you for the similar care in a Medicare contracted facility in the United States.

Claims incurred both inside and outside of the U.S. must have medical records and or itemized superbill along with receipts. Medical records submitted for foreign claims will be sent for translation by Hometown Health.

Members have 90 days to submit the request and documentation after services are rendered.

To ensure faster processing of your claim, BE SURE TO DO THE FOLLOWING:

- If you write on the form, use black or blue ink and print clearly and legibly. You can also use your computer to complete this form and then print it out to mail it to us. Complete all the applicable fields on the form.
- Ask your provider for their Provider Information or have them fill it out for you.
- Be sure to submit a separate form for each date of service.
- Once you have completed the form, follow the submission instructions on the back of the form.
- Be sure to attach the Superbill or Invoice and any receipts of your payments. The Superbill or Invoice must have CPT and diagnosis codes included.

IF YOU HAVE OTHER INSURANCE OR MEDICARE

and it is primary to your Hometown Health Plan/Senior Care Plus Plan, please include the explanation of benefits (EOB) from your other insurance or Medicare. We will process your member reimbursement up to 90 days after you receive the EOB from your primary insurance.

WHAT HAPPENS NEXT?

After we process your claim, we will send you an Explanation of Benefits (EOB). The EOB will explain the charges applied to your plan deductible and out of pocket maximum as well as any charges you owe your health care provider.

Please keep your EOB on file for future reference. You also may review your EOB information via MyChart App.

FOR PHONE CLAIMS AND INQUIRIES PLEASE CALL:
Hometown Health **775-982-3232** or **800-336-0123** • Senior Care Plus **775-982-3112** or **888-775-7003**
10315 Professional Cir. • **Reno, NV 89521** • **hometownhealth.com** • **SeniorCarePlus.com**

Hometown Health Senior Care Plus

REIMBURSEMENT CLAIM FORM

Member ID *(See ID Card)* _____ **Group Number** *(See ID Card)* _____

PATIENT INFORMATION

Last Name _____ First Name _____ Middle Initial _____

Home Address _____

City _____ State _____ Zip _____

Phone _____ Date of Birth (mm/dd/yyyy) _____

Gender ☐ Male ☐ Female

Relationship to Subscriber/Policyholder

☐ Subscriber/Policyholder ☐ Spouse/Partner ☐ Child ☐ Other Dependent

POLICYHOLDER INFORMATION

Complete This Section Only If It Is Different Than The Patient Information.

Subscriber Last Name _____ First Name _____ Middle Initial _____

Home Address _____

City _____ State _____ Zip _____

Phone _____ Date of Birth (mm/dd/yyyy) _____

PROVIDER INFORMATION

This Information Is Required To Process The Claim.

Ask Your Provider For This Information Or Have Them Fill it Out for You.

Provider Name *(or Rendering Provider Name)* _____

Provider Address _____

City _____ State _____ Zip _____

Phone _____ Provider NPI Number _____

Provider Tax Identification Number _____ Group/Facility Name _____

Address Where Services Were Rendered _____

City _____ State _____ Zip _____

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OTHER INSURANCE

Is The Patient Covered By Another Insurance Plan?

☐ ***YES*** ☐ ***NO*** (If yes, please complete the following information.)

Name of Person Carrying Other Insurance

Last Name _____ First Name _____ Middle Initial _____

Date of Birth of Person Carrying Other Insurance (mm/dd/yyyy) _____

Name of Other Insurance Carrier _____

Policy Number _____

Employer Name _____

Effective Date of Other Insurance (mm/dd/yyyy) _____

Cancellation Date of Other Insurance (mm/dd/yyyy) *IF APPLICABLE* _____

Did You Attach an EOB from Medicare or Your Other Insurance?

☐ ***YES*** ☐ ***NO***

ASSIGNMENT OF BENEFITS

☐ **Please Check This Box if You Want Hometown Health to Pay Benefits Directly to the Doctor/Provider.**

By signing below, I am stating that the information above is correct. 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.

Signature _____ Date (mm/dd/yyyy) _____

Reimbursement Claim Form Submission Instructions

ONCE COMPLETE, you can submit the Reimbursement Claim Form the following ways:

Email **Customer_Service@HometownHealth.com**

Mail / Dropoff – Attention: **Claims Department**

Hometown Health • **10315 Professional Cir.** • **Reno, NV 89521**

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