Medicare Advantage Reimbursement Form

PLEASE PRINT ALL INFORMATION CLEARLY

MEMBER INFORMATION			
Member Identification Number	Last name	First Name	Middle Initial
Address – Number and Street		City	State
Zip code			
Gender 1. ☐ Male 2. ☐ Female	Date of Birth Mo. Day Year / /		

SUBMISSION INSTRUCTIONS:

- Verify if you are eligible for this benefit in your Evidence of Coverage (EOC) document.
- You can submit one (1) or multiple requests up to the allowed $ amount in paid receipts for qualified services.
- Submit this form along with an itemized receipt(s) and copy of your health ID card.

TYPE OF SERVICE:	DATE OF SERVICE/PURCHASE	AMOUNT YOU PAID
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
TOTAL AMOUNT SUBMITTED:		$_____

BENEFIT REQUIREMENTS:
Prior to submitting this reimbursement request, please verify if all the benefit requirements are met. You can check that by visiting Chapter 4 of your Evidence of Coverage (EOC) document. The requirements are listed under the benefit for which you are requesting the reimbursement. If your benefit requirements are not met, your request may get denied.

CERTIFICATION AND AUTHORIZATION (This form must be signed and dated below)
I authorize the release of any information to Braven Health about my services used as part of this benefit. I certify that the information provided in support of this submission is complete and correct and that I have not previously submitted above the allowed amount for these services within this calendar year.

Member's Signature: _____Date:_____

Mail this Medicare Advantage Reimbursement Form AND attach your original receipt(s) to:

Braven Health
PO Box 1609
Newark, New Jersey 07101-1609

Braven Health complies with applicable Federal civil rights laws and does not discriminate against nor does it exclude people or treat them differently on the basis of race, color, gender, national origin, age, disability, pregnancy, gender identity, sex, sexual orientation or health status in the administration of the plan, including enrollment and benefit determinations.

Spanish (Español): Para ayuda en español, llame al **1-833-272-8360** (TTY **711**).
Chinese (中文): 如需中文協助**'**請致電 **1-833-272-8360** (TTY **711**) °

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