Hamaspik Medicare

Reimbursement Request Form

Directions
1. This form must be completely filled out to process your reimbursement 2. Attach a copy of all receipt(s) to the back of this form 3. Please submit within 90 days from the date the services/items were obtained 4. Receipts should contain as much of the following information as possible; a. Service(s) / Item Description(s) b. Date of Service(s) / Date Item(s) purchased c. Vendor / Provider name and Telephone number d. Amount paid e. Insurance used for partial payment/ co-pay f. Requested reimbursement 5. Mail to: **Hamaspik, Inc.** **775 N. Main St.** **Spring Valley, NY 10977** 6. If you have any questions please contact us at 888-426-2774. (TTY users call 711).

Member Information	
Member Full Name:	Member ID Number:
Mailing Address:	Phone Number:
City: State:	Zip:

I am requesting reimbursement because:
☐ You have not received your ID Card
☐ The vendor/provider is not in the network
☐ It was an emergency - Please describe the emergency on a separate sheet
☐ The provider system was down
☐ You did not have your ID card and the provider could not verify eligibility
☐ There were not any network providers available
☐ Other - Please describe on a separate sheet

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Other Insurance Coverage Information
Are you eligible for primary prescription drug coverage from another insurance company?
☐ Yes
☐ No
Other Insurance Company's Name:
Group Number:
Member ID Number:
Effective Date of Coverage:

Provider Information				
#	Provider Name	NPI Number	Phone Number	State
1				
2				
3				
4				

Enrollee Signature

Notice: Reimbursement for this claim is subject to your plan's covered benefits and services and is not guaranteed. Please note that some services require an authorization, and Hamaspik may request medical records from your provider in order to make a decision. Reimbursement will be made according your plan benefit package and is subject to your plan's covered benefits and services.

Any person who knowingly and with intent to defraud, injure or deceive any insurance company, submits a claim or application containing any materially false, deceptive, incomplete or misleading information pertaining to such claim may be committing a fraudulent insurance act, which may subject such a person to criminal or civil penalties, including fines, denial of benefits, and/or imprisonment.

I certify that I (or the individual for whom I am the Authorized Representative) have received the item/ service(s) described herein. I certify that I have read and understood this form, and that all the information included on this form is true and correct.

Signature: _____ **Date: _____**

REMINDER: To avoid having to submit a reimbursement request
✓ Always have your ID card at the time of rendering all services and benefits
✓ Always use providers in your network and ensure they have your ID and insurance information.
✓ Use items covered under your OTC formulary
✓ Call Member Services 888-426-2774 for immediate resolutions