MMM
Medicare y Mucho Más

Member Reimbursement Form

Instructions:

1. **Please fill out the following information.**
2. **Be sure to include all required information and documents identified with symbol ✓.**
3. **Include your signature.**
4. **If you wish to mail the information, please return it to Medicare y Mucho Mas at the address listed on the back.**

Date _____ Submitted by: _____

Member Name _____

ID Number _____ (Number on your plan card)

Dirección postal _____

_____

_____

Telephone Number _____

Please verify that the following documents are included.

✓ **Original receipt stamped by the providers' office** or a **HCFA 1500/UB-04** form with the following information:

✓ **Service Date**:_____

✓ **Provider Name**: _____

✓ **Rendering Provider NPI**: _____(National Provider Identifier).

✓ **Diagnosis:** _____

✓ **Procedure Code:**

1._____ 2._____ 3._____ 4._____ 5._____

6._____ 7._____ 8._____ 9._____ 10._____

✓ **Amount paid** : _____

[ ] **Other**:_____

Was your visit with a non-contracted provider? Yes [ ] No [ ]

If your answer to the previous question was Yes, please provide the following additional information:

- ✓ **Name of Referring Provider** (Include full name)_____
- ✓ **Provider's office number** _____
- ✓ **Referral Reason**:_____

_____

_____

If you have any questions or need further information, call our Member Services Department at 787-620-2397, 1-866-333-5470 (tall free) or at 711 TTY (Hearing Impaired). Our office hours are Monday through Sunday 8:00 a.m. - 8:00 pm.

If you wish to send by postal mail, send to the following address:

Medicare y Mucho Más
Claims Member Reimbursement
PO Box 71305
San Juan, PR 00936-8405

✓ **Member´s Signature** _____ ✓ **Date** _____

If you are an authorized representative, please complete the following fields by submitting any of the following documents: power of attorney, valid AOR form or equivalent document.

✓ **Authorized Representative Name** (in print)_____

✓ **Signature of Authorized Representative** _____✓ **Date** _____