✓MetroPlusHealth

MEDICARE MEMBER DIRECT REIMBURSEMENT REQUEST FAQS

WHEN CAN I REQUEST REIMBURSEMENT FOR A MEDICAL SERVICE OR ITEM?

If you have already paid for a service or item covered by your MetroPlusHealth plan, you can ask us for payment. Asking for reimbursement is asking MetroPlusHealth for a "coverage decision".

Here are some examples of situations in which you may need to ask our plan to pay you back:

- ✓ You did not have your ID card at the time of service and you paid out-of-pocket for any of your covered services or items
- ✓ When you have received emergency or urgently needed medical care from a provider who is not in our plan's network
- ✓ If you are retroactively enrolled in our plan and you paid out-of-pocket for any of your covered services or items after your enrollment date
- ✓ If you are eligible for Gym Reimbursement every six (6) months and are requesting a reimbursement of your gym membership fees

HOW MUCH TIME DO I HAVE TO SUBMIT A REQUEST FOR DIRECT REIMBURSEMENT?

- ✓ You have **365 days** (1 year) from the date you received the service.

HOW DO I ASK METROPLUSHEALTH FOR REIMBURSEMENT?

You can request reimbursement by writing to MetroPlusHealth or completing the **Direct Member Reimbursement (DMR) Form.**

- ✓ You don't have to use the form, **but it will help us process the information faster**.
- ✓ You can either download a copy of the form from our website (https://www.metroplus.org/Plans/Medicare/grievance-appeals) or **call Member Services at 1.866.986.0356 (TTY: 711, 7 days a week, 8am-8pm) and ask for the form to be mailed to you.**
- ✓ **Please mail and sign your request for reimbursement together with proof of payment to us at this address:**

MetroPlus Health Plan
Attn: Claims Department
50 Water Street, 7th Floor
New York, NY 10004

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WHAT MUST I SUBMIT TO BE REIMBURSED, AND WHAT IS "PROOF OF PAYMENT"?

✓ An **itemized bill** from the doctor who treated you or the service provider who provided you with a service.

- **The itemized bill must include proof of your payment to the doctor or service provider** (e.g., check #, credit card receipt, money order # or amount paid in cash), **and:**

1. **The itemized bill must include the date(s) of service** (each date you were treated);
2. **Procedure codes for each service, diagnosis codes, a description of each service performed, and the doctor or service provider's contact information** (i.e., credentials, name, address, telephone number, fax number, email); and
3. **Provider Tax ID (NPI or TIN)**

- **The itemized bill should also be signed and dated by the doctor, service provider or office manager and should include their letterhead or logo.**
- **The itemized bill should include proof of payment**, i.e., sales receipt with a copy of your cancelled check or money order (front & back) or credit card receipt which matches the billed service amounts on the itemized bill.

HOW SOON WILL METROPLUSHEALTH RESPOND TO ME?

✓ **We must provide a written response to you within 30 calendar days** after we receive all the necessary information from you.

WHAT AM I RESPONSIBLE FOR?

✓ Y**ou only have to pay your cost-sharing amount when you get services covered by our plan. Cost-sharing may include** deductibles, copayments and/ or coinsurance depending on the service or item and the plan in which you are enrolled. **We will pay you back for our share of the cost.**

WHAT HAPPENS IF METROPLUSHEALTH DENIES A PORTION OF MY REQUEST OR MY ENTIRE REQUEST?

✓ **If we denied your request for reimbursement, we will send you a written statement that explains why we said no. You will have 60 calendar days from the date of the denial notice we mailed you to appeal our decision.** If you miss this deadline and have a good reason for missing it, we may give you more time to make your appeal.

WHAT HAPPENS IF I AM TOLD THAT MY REQUEST CANNOT BE PROCESSED BECAUSE OF MISSING INFORMATION?

- ✓ **You will have to submit the missing information to us so that we may process your request.** If you do not provide this information to us within **60 calendar days** from when we received your request for payment, your request will be dismissed. We will mail you a letter to explain next steps and how to send us the information we need to address your request.

WHAT HAPPENS IF MY REQUEST IS DISMISSED?

- ✓ **If your request for payment is dismissed, you can submit a new request along with all the supporting documentation again to MetroPlus**Health **within 365 days of the date of service**. You also have the right to request the Independent Review Entity (IRE) to review the dismissal within **60 calendar days** after receipt of our plan's dismissal notice.