DIRECT MEMBER REIMBURSEMENT FORM

This form is used for members who have paid out of pocket and are requesting reimbursement. You must submit your claim to us within 365 days of the date you received medical services. This form is only applicable to medical reimbursement. Our prescription reimbursement form can be found at www.apexhealth.com. Please see the instructions at the end of this form. Please note that the use of a claim form, such as this Direct Member Reimbursement Form, is not required to receive a reimbursement.

Instructions:

1. **Complete this form and attach your bill, receipts, and any other documentation related to this reimbursement request. Forms without the required information may delay the processing of your request.**

   IMPORTANT: This information must be on the bill or invoice you submit as it is required to process the claim. Missing information can result in a delay or non-payment of the claim.

   - Name and address of provider (doctor, hospital, laboratory, Tax ID, etc.)
   - Name of Patient
   - Procedure Code(s)
   - Date of service
   - Amount charged for each service
   - Diagnosis code

   *If you do not have a document with this information, ask your provider to give you a bill or invoice that includes all the above for each date of service.

2. **Once you have completed the form, mail it to:**

   ATTN: DMR
   ApexHealth
   96 Kercheval Avenue, Suite 200
   Grosse Pointe Farms, MI 48236

   Be sure to attach the itemized invoice or bill and any receipts as proof of your payments.

What happens next:

- It can take up to 60 days to process the direct member reimbursement request
- If approved, we will send you an Explanation of Payment (EOP) with a check for applicable reimbursement based on your plan benefits

For questions, please call Concierge Services at (844) 279-0508 (TTY 711). We're available from 8 a.m. to 8 p.m. local time, 7 days a week between October 1 and March 31 and 8 a.m. to 8 p.m. local time, Monday- Friday between April 1 and September 30.

REASON FOR REIMBURSEMENT

- ☐ **Did not use my ApexHealth ID card**
- ☐ **Went to a non-participating provider** ***(Please provide details in the Explanation area.)***
- ☐ **Provider or supplier refused/unable to file a claim for covered services**
- ☐ **Have primary coverage with another insurance carrier** ***(Please include your Explanation of Benefits (EOB) or the denial letter from your primary insurance carrier as well as your other health insurance coverage information.)***
- ☐ **Was waiting for a medical referral or approval**
- ☐ **Traveled out of the country**
- ☐ **Other**

***Explanation*:**

MEMBER INFORMATION

Member ID number (on the front of your ApexHealth ID card):_____

Member name:_____ Member sex: ☐ Male ☐ Female

Member birth date: Month_____ Day_____ Year_____ Daytime phone: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Mailing Address (if different): _____

City: _____ State: _____ Zip: _____

I am the: ☐ Member ☐ Beneficiary Representative*

**If you are filling this form out for someone other than yourself, please see instruction #6 at the end of the form for further steps.*

MEMBER CERTIFICATION

I represent that the member information entered on this form is correct, that the member named is eligible for the benefits and that the member has received the service described. I also represent that the treatment received is not for treatment of an on-the-job injury. I also authorize release of all information pertaining to this claim to the plan administrator or its designees. Any person who knowingly and with intent to defraud any insurance company or other person: (1) files an application for insurance or statement of claim containing any materially false information; or (2) conceals for the purpose of misleading, information concerning any material fact thereto, commits a fraudulent insurance act which is a crime.

Member Printed Name:

Member signature: Date:

Beneficiary Representative (if applicable): Date:

MEDICAL CLAIM INFORMATION
(Complete applicable information)

Date of service:	**Dollar amount requested:**
Description of service (diagnosis code, procedure code if available):	
Provider's name:	**Provider's phone:**
Provider's street address:	
Provider's city:	**State:** **Zip Code:**

INSTRUCTIONS

1. Complete all sections of this form, including your signature and date in the Member Certification statement.
2. Submit a separate form for each request.
3. Include receipts or printed invoices that show a detailed list of the services received, the date you received the service(s) or item(s), and amounts paid. Claims missing information may result in this request being denied.
4. If you do not have a detailed receipt for each service related to your request, you can ask your doctor or provider for a replacement receipt or a patient printout. The receipt must show proof of payment.
5. Keep a copy of these receipts for your records.
6. If you are submitting this request for someone other than yourself, please include the required Appointment of Representative (AOR), Power of Attorney or Executor of Estate form. The AOR form can be found at: cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/CMS1696.pdf or on our website, www.apexhealth.com
7. Mail your request to:

   ATTN: DMR
   ApexHealth
   96 Kercheval Avenue, Suite 200
   Grosse Pointe Farms, MI, 48236

8. If you need help completing this form, please call us at: 1-844-279-0508 (TTY:711) to learn how to name your representative. Hours of operation are 8 a.m. to 8 p.m. local time seven days a week from October 1 to March 31, and 8 a.m. to 8 p.m. local time Monday-Friday from April 1 to September 30.

IMPORTANT REMINDERS

1. The Direct Member Reimbursement Form must be submitted within one year of the date you received the specific service or benefit
2. If your DMR Claim Form is incomplete, there may be delays in processing and the potential for a denial. Our team of ApexAssistants will reach out to you to obtain additional information if needed to process your request.
3. Once your request for reimbursement is approved, it can take up to 60 days for ApexHealth to send your reimbursement