Member Medical Reimbursement Claim Form

FAX form and any required documents to **1-813-283-3284** OR
MAIL to 'Ohana Member Reimbursement Department • P.O. Box 31370 • Tampa, FL 33631
Use this claim form to be reimbursed for eligible out-of-pocket medical expenses.
Please submit one form per member.

Member Name _____ Member ID # _____

Address _____ Telephone: _____

City _____ State _____ ZIP Code: _____

Please provide a brief description of your request:

Date of Service	Provider Name	Description of Service	Amount Requested

Total Amount of Reimbursement Request _____

I attest that the above information is true and accurate and that the services were received and paid for in the amount indicated above. I acknowledge that if any information on this form is misleading or fraudulent, I may be subject to criminal and/or civil penalties for submitting false healthcare claims.

Printed Name: _____ Signature:_____ Date:_____

HOW TO FILL OUT THIS FORM

FOLLOW THESE INSTRUCTIONS CAREFULLY:

A. Completion of this form.

- Print your name like it is on your ‘Ohana ID Card.
- Print your Member ID number.
- Print your mailing address and telephone number.
- Tell us why you seek reimbursement.
- Give us the date of service for which you seek reimbursement. (This is the date you got the service.) List separately each date of service or admission date for inpatient/hospital stays.
- Print the name of the doctor or facility that gave you the service.
- Tell us about the service that was provided. (Was this for travel ? Add mileage.)
- State the amount you seek for the individual service line.
- Add all individual lines together and state the total amount you seek.

B. Each itemized bill MUST include all of the following information:

- Date of each service
- Place of each service

Doctor’s Office	**Independent Laboratory**	**Outpatient Hospital**
Nursing Home	**Patient’s Home**	**Inpatient Hospital**

- Description of each surgical or medical service or supply given
- Charge for each service
- Doctor’s or supplier’s name and address. Many times, a bill will show the names of several doctors or suppliers. **Please note:** IT IS VERY IMPORTANT THAT YOU IDENTIFY THE ONE WHO TREATED YOU. Just circle the name on the bill.

C. Proof of Payment documentation:

- Copy of canceled check (front and back)
- Credit card statement showing payment to provider
- Invoice/statement from provider showing provider’s name, address, telephone number, date(s) of service, services provided and balance marked paid with method of payment – cash, check or credit card

‘Ohana will review your request for reimbursement after you complete this form. Please attach an itemized bill and payment receipt from your doctor or supplier. All requests will be processed within 60 days of receipt. **Please note**: Your bill must be paid in full **before** you can submit this request for reimbursement. All required documentation must be included with the request. Mail your completed form/documents to PO Box 31370, Tampa, FL 33631 or fax to **813-283-3284**.

‘Ohana Health Plan complies with applicable Federal civil rights laws and does not discriminate, exclude people, or treat people differently because of race, color, national origin, age, disability or sex.

‘Ohana Health Plan provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

‘Ohana Health Plan provides free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services, contact **1-888-846-4262** (TTY **711**).

If you believe that ‘Ohana Health Plan has failed to provide these services or discriminated in another way, you can file a grievance with:

‘Ohana Health Plan
Attn: Grievance Department
949 Kamokila Boulevard
Suite 350
Kapolei, HI 96707
Toll-free: **1-888-846-4262**
TDD/TTY: **711**
Fax: **1-813-865-6861**

You can file a grievance in person or by mail or fax. If you need help filing a grievance we are available to help you. Call Customer Service toll-free at **1-888-846-4262** (TTY: **711**).

You can also file a grievance with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, **800-537-7697** (TDD)

Complaint forms are available at **http://www.hhs.gov/ocr/office/file/index.html**.

(English) Do you need help in another language? We will get you a free interpreter. Call **1-888-846-4262** (TTY: **711**).

(Cantonese) 您需要其它語言嗎？如有需要，請致電 **1-888-846-4262**，我們會提供免費翻譯服務 (TTY: **711**)。

(Chuukese) En mi niit alilis lon pwal eu kapas? Sipwe angei emon chon chiaku ngonuk ese kamo. Kori **1-888-846-4262** (TTY: **711**).

(French) Avez-vous besoin d'aide dans une autre langue? Nous pouvons vous fournir gratuitement des services d'un interprète. Appelez le **1-888-846-4262** (TTY: **711**).

(German) Brauchen Sie Hilfe in einer andereren Sprache? Wir koennen Ihnen gern einen kostenlosen Dolmetscher besorgen. Bitte rufen Sie uns an unter **1-888-846-4262** (TTY: **711**).

(Hawaiian) Makemake `oe i kokua i pili kekahi `olelo o na `aina `e? Makemake la maua i ki`i `oe mea unuhi manuahi. E kelepona iā **1-888-846-4262** `oe ia la kaua a e ha`ina `oe ia la maua mea `olelo o na `aina `e. (TTY: **711**).

(Ilocano) Masapulyo kadi ti tulong iti sabali a pagsasao? Ikkandakayo iti libre nga paraipatarus. Awagan ti **1-888-846-4262** (TTY: **711**).

(Japanese) 貴方は、他の言語に、助けを必要としていますか？私たちは、貴方のために、無料で 通訳を用意で きます。**1-888-846-4262** (TTY: **711**) まで、お電話にてご連絡ください。

(Korean) 다른언어로 도움이 필요하십니까? 저희가 무료로 통역을 제공니다. **1-888-846-4262** (TTY: **711**) 번으로 전화해 주십시오.

(Mandarin) 您需要其它语言吗？ 如有需要，请致电 **1-888-846-4262**，我们会提供免费翻译服务 (TTY: **711**)。

(Marshallese) Kwoj aikuij ke jiban kin juon bar kajin? Kim naj lewaj juon am dri ukok eo ejjelok wonen. Kaalọk **1-888-846-4262** (TTY: **711**).

(Samoan) E te mana'o mia se fesosoani i se isi gagana? Matou te fesosoani e ave atu fua se faaliliu upu mo oe. Telefoni mai: **1-888-846-4262** (TTY: **711**).

(Spanish) ¿Necesita ayuda en otro idioma? Nosotros le ayudaremos a conseguir un intérprete gratuito. Llame al **1-888-846-4262** (TTY: **711**).

(Tagalog) Kailangan ba ninyo ng tulong sa ibang lengguwahe? Ikukuha namin kayo ng libreng tagasalin. Tumawag sa **1-888-846-4262** (TTY: **711**).

(Tongan) 'Oku ke fiema'u tokoni 'iha lea makehe? Te mau malava 'o 'oatu ha fakatonulea ta'etotongi. Telefoni mai **1-888-846-4262** (TTY: **711**).

(Vietnamese) Bạn có cần giúp đỡ bằng ngôn ngữ khác không? Chúng tôi se yêu cầu một người thông dịch viên miễn phí cho bạn. Gọi số **1-888-846-4262** (TTY: **711**).

(Visayan) Gakinahanglan ka ba ug tabang sa imong pinulongan? Amo kang mahatagan ug libre nga maghuhubad. Tawag sa **1-888-846-4262** (TTY: **711**).