eternalHealth™

MEDICARE MEMBER MEDICAL CLAIM REIMBURSEMENT FORM

Please remember to keep a copy of the completed claim form and receipt(s) for your records.

Send the completed form (all pages) and all receipt(s)
to: ATTN: P.O. Box 1263, Westborough, MA 01581

Instructions

Note: Forms with insufficient information cannot be processed. This form must be filled out completely. Incomplete forms will be returned. Manual submission of claims does not guarantee reimbursement. Member must be eligible at the time services are rendered. Services must be a covered plan benefit that meets all plan policies.

In the event that your provider receives an overpayment from you, eternalHealth will reimburse you for the amount you paid minus the applicable cost-sharing amount.

If you or your provider need assistance or have any questions, please call Member Services at **800-680-4568**.

1. Complete this form in its entirety.

- Please submit claims within 1 year of date of service. If you have any questions, please call Member Services at 800-680-4568.
- Please carefully go through the form and fill out all Parts that apply.
- Provide details about your claim including the amount paid, date of service, and description of service or item you received.
- Submit a separate form for each reimbursement request.

IMPORTANT NOTE: Payment & related correspondence will be sent to the member address on file unless you provide us with an Alternate Payment Address in Part 1.

2. Attach all supporting documentation to your completed form, including an itemized bill with proof of payment.

Include an itemized bill with the required medical information:

- Date of service
- Description of each surgical or medical service or item provided
- Charge for each service or item
- Provider Identifier (not applicable for emergency services outside of the U.S.)

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*** Required Information**

PART 1: Member Information

Provide the required information. Member information is located on your Member ID Card.

Member Name*	Member ID #*	Member Date of Birth* (MM/DD/YYYY)

Member Address		
City	State	Zip Code

Alternate Payment Address (if different from member address)		
City	State	Zip Code

PART 2: Provider Information

Reach out to your provider for the following information. Provider Identifier is not applicable for emergency services outside of the United States.

Provider Name*	Provider ID*

Provider Address*		
City*	State*	Zip Code*

Phone*	Fax

PART 3: Other Health Insurance Information

Please leave this section blank if you do not have additional health insurance coverage.
If your other insurance is your primary insurance, please attach a copy of its Explanation of Benefits (EOB).

Name of Other Health Insurance	Policy Number

Health Insurance Address		
City	State	Zip Code

eternalHealth
Your Forever Partner in Healthcare

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PART 4: Claim Information

Submit a separate form for each reimbursement request.

Reason for Submitting This Claim*

- ☐ The provider or supplier refused to file a claim for Medicare Covered Services
- ☐ The provider or supplier is unable to file a claim for the Medicare Covered Services
- ☐ The provider or supplier is not participating with eternalHealth
- ☐ Other (Please Specify): _____

Amount Paid*	Date of Service (MM/DD/YYYY)*

Description of Service and/or Item*

PART 5: Supporting Documentation

Attach all supporting documentation to your completed form, including an itemized bill with proof of payment.
The itemized bill must contain the required medical information:

- Date of service
- Description of each surgical or medical service or item provided
- Charge for each service or item
- Provider Identifier (not applicable for emergency services outside of the U.S.)

PART 6: Disclaimer and Signature

I certify that my answers are true and complete to the best of my knowledge.

Member Signature*	Date (MM/DD/YYYY)*

Important Claim Notices

Caution: Any person who knowingly and with intent to, injure, defraud, or deceive an insurance company, files a claim containing false, incomplete, or misleading information may be prosecuted under state law and subject to civil fines and criminal penalties.