group health Cooperative of eau claire

2503 N. Hillcrest Parkway
Altoona, WI 54720

T. 800.460.4641
F. 715.836.7683

group-health.com

Reimbursement Instructions

How to Complete This Direct Member Reimbursement (DMR) Form

When to use this form:

- Fill out this form if you're asking for a medical, or vaccine reimbursement and you paid a doctor, healthcare professional, or service provider who did not bill us directly.
- Do not use this form for prescription drug, dental, vision, or hearing claim reimbursements. Use the contact information below for these services.
    - For prescription drug claims, visit group-health.com/cooperative-advantage or call the Express Scripts customer service number at 866-220-6512 to get a prescription drug claim form.
    - For dental claims, visit **www.deltadentalwi.com/s/medicare-advantage** or call the Delta Dental customer service number at 866-548-0292
    - For vision claims, visit vsp.com or call the VSP Vision customer service number at 855-492-9028.
    - For hearing claims, visit hearingcaresolutions.com or call the HCS customer service number at (866-344-7756)

How to fill out this form:

1. Complete each section. Print clearly in black ink only. If you need another form, you can download the PDF at **group-health.com/cooperative-advantage** and print it.
2. Submit itemized receipts with this form.
3. Sign and date the bottom of the completed form. Appointed representatives must have an Appointment of Representative form on file, or you can submit one with this form. You can find an Appointment of Representative form at **group-health.com/cooperative-advantage**.

Where to send this form:

	Group Health Cooperative of Eau Claire
Fax:	715-836-7683
Mail:	2503 N. Hillcrest Parkway, Altoona, WI 54720

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Things to remember:

1. Please submit the form within 365 days from the date you received the service or item.
2. If the form is incomplete, processing delays may occur while we find the needed information.
3. If we approve your request, it can take up to 45 days to send payment once we have all the required information.

Acknowledgment

I understand it is a crime to fill out this form with information I know is false. I understand the submission of a claim is not a guarantee of payment, or payment in the full amount. I understand if the services are deemed covered services then the health plan will reimburse me up to the benefit amount minus any applicable deductibles, coinsurance, or copays. I understand Cooperative Advantage may need to disclose the information on the form to other persons and entities to process the claim.

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Direct Member Reimbursement Medical

Member information (print clearly):		
Member Full Name:		
Member ID#:	Date of Birth:	Phone Number:
Address:		
City:	State:	ZIP Code:
Email Address (optional):		

Doctor, healthcare professional, or supplier information:		
Provider Name:		
Does the provider accept Medicare? ☐ Yes ☐ No	Phone Number:	
Address:		
City:	State:	ZIP Code:

Claim request (information must match your itemized bill):	
Date of Service or Procedure:	Amount Paid:
Description of Procedure(s), Service(s), or Item(s):	

Signature	
By signing and submitting this form, I certify that the information is true and correct.	
Member or Authorized Representative Signature:	Date:

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If you have any questions, please call Group Health Cooperative of Eau Claire at 1-800-460-4641. TTY users should call 711. Representatives are available:

- October 1 – March 31, 8 AM to 8 PM, 7 days a week.
- April 1 – September 30, 8 AM to 8 PM, Monday through Friday