Sentara Health Plans

MEDICAL/BEHAVIORAL
Direct Member Reimbursement Form
NOTE: Only use this form for Medical and Behavioral Health services.

Complete this form to request reimbursement for covered services.

Completion and submission of this form to Sentara Health Plans does not guarantee reimbursement. Claims are subject to limitations, exclusions, and other provisions of your Benefit Plan. Applicable reimbursement can only be made payable to the primary cardholder.

☐ **MEDICARE MEMBER** ☐ **MEDICAID MEMBER** ☐ **COMMERCIAL MEMBER**

MEMBER INFORMATION (Submit a separate form for each family member)		
Member Name: (First, Last, Middle Initial)	Birth Date:	SHP Member Number
Mailing Address: (Address, City, State, Zip)	Telephone Number: Email:	
Provider's Name	Provider's Telephone Number:	Provider's Tax ID #:

REASON FOR MEDICAL REIMBURSEMENT

☐ Illness OR ☐ Injury? Date of Illness or Injury: Date of Service:

Description of illness or injury. Please include where the injury occurred.

Member Signature:	Date Signed:

IMPORTANT CHECKLIST

To ensure timely processing, please review and complete this checklist prior to mailing your request.

- ☐ The form is completely filled out.
- ☐ Documents are in English, clear and legible. If not in English, please provide translated records together with your form.
- ☐ Attach an itemized bill from the provider of service. This must include the date of service, procedure codes for each service, diagnosis code, a description of the service performed, and the provider's contact information and Tax ID #.
- ☐ Attach proof of purchase; Sales receipt, a copy of canceled check (front & back) matching the billed services, etc. Sign and Date form.

Sentara Health Plans has a timely filing limit for claim submissions. Claims must be received within 365 days from the date of service. Once the claim is received, please allow time for us to complete your claim according to our normal processing times (typically 14 to 30 days). If any monies are due to the member/patient, please allow additional time for check processing and mailing via USPS.

Mail this completed form and all documents to:
SENTARAH HEALTH PLANS MEDICAL CLAIMS
Attention: Member Reimbursement
P.O. Box 8203
Kingston, NY 12402-8203