REIMBURSEMENT APPLICATION

☐ **MEDICAL** ☐ **DENTAL**

To complete the form, please read the instructions

MCS Classicare (HMO)

SECTION A - MEMBER INFORMATION

Contract Number	Member First Name	Initial	Member Last Name

Postal Address (Urb., Street Number, PO Box, City, State, Zip Code)

Group Number	Group Name	Date of Birth
Home Phone Number	**Cellular Phone Number**	**Benefit Plan**

Date of Service	Procedure Code(s)	Place of Service (Office / Hospital / Home / Other)	Description	Total Cost	Patient Payment

Diagnosis Code(s)

A.	B.	C.	D.	E.	F.
G.	H.	I.	J.	K.	L.

Provider who performed the services:	NPI Number:	Employer Identification Number:	State License Number:	Specialty:

Brief explanation of why you need to use the services and reimbursement thereof:

SECTION B - OTHER PLAN INFORMATION/ COORDINATION OF BENEFITS

Does the member have another health plan? ☐ Yes ☐ No

Name of health plan	Effective Date

Policy number / contract

What type of coverage do you have with the other plan? [ ] Individual [ ] Couple [ ] Family	Plan Telephone Number

¿What benefit coverage do you have with the other plan?
[ ] Medical [ ] Dental [ ] Pharmacy [ ] Vision

SECTION C - ACCIDENT OR INJURY INFORMATION (if applies)

The condition or lesion is related to:

[ ] Work accident

[ ] Car Accident

[ ] Other accident, explain:

Date of accident: ____ / ____ / ____	Where did the accident occur?

How did the accident occur?

SECTION D - AUTHORIZATION OF MEMBER

I Certify that the information provided on this reimbursement application is correct and complete. I authorize any physician, hospital or other medical facility to provide information required for MCS analysis of this request for reimbursement.

_____ Signature of member or authorized representative

_____ Date

FOR INTERNAL USE OF MCS - CLASSICARE

Effectiveness: ☐ Active ☐ No Active	Amount to be paid:
Verification of premium payment:	Date:
Verified by:	Comments:
Approved services by:	

ADDITIONAL INFORMATION FOR DENTAL REIMBURSEMENT

Piece Number: | | | | | | | Surface (if restoration)

INSTRUCTIONS

I. PLEASE READ THIS VERY IMPORTANT INFORMATION

Use this form to request reimbursement of medical and dental expenses covered and incurred by non-participating providers when applicable.

If you claim expenses for more than one provider (medical, hospital, laboratory), you must attach the official receipt for each vendor who served.

Complete the boxes on the procedure form for reimbursement. Include detailed receipts in original for all services supplied or claimed.

Receipts for reimbursement must be legible and must include the following information:

- **A.** Original official receipt- The original receipt must have the logo or seal of the service provider. This receipt must contain the provider's name, address, phone number and specialty.
- **B.** National Provider Identifier (NPI) number, Employer Identification Number and State License Number.
- **C.** Complete name of member
- **D.** Contract number of member
- **E.** Date of service (month / day / year)
- **F.** Description of the service received. If the receipt is for more than one service, each service has to be detailed. Laboratory receipts must specify all lab tests conducted to the patient.
- **G.** Enter the code and description of diagnosis (number that identifies the diagnostic - ICD-10) and description of the diagnosis.
- **H.** Indicate the paid cost of each detailed service.
- **I.** The receipt must indicate the tooth or the workpiece (**only applies to Dental**).
- **J.** Include side of the workpiece. Each surface has separate fee (**only applies to Dental**).

Note: Individual cash recepits, canceled checks, receipts for money orders, personal breakdowns and invoices indicating only "Balance Due" are not acceptable.

Forms that do not contain the requested information may delay the processing of your refund or be returned to you.

You can send the form by mail to: MCS, PO BOX 191720 San Juan PR 00919-1720. You can also deliver in person to: MCS Plaza, Suite 105.

If you have any questions regarding how to complete this form or any related questions please contact our Service Call Center for Members at 787-620-2530 (Metro Area) or 1-866-627-8183 (Toll Free). For TTY you can call 1-866-627-8182 from Monday to Sunday from 8:00 am to 8:00 pm.

II. CONFIDENTIALITY NOTE

This formulary, once completed, contains privileged and confidential information for exclusive use of the person or entity it addresses. If you receive it by mistake, you are not authorized to review, disclose, spread, distribute or photocopy it. If you received this information by mistake please notify immediately at 787-758-2500 to make arrangements to return or destroy the documents.

III. FRAUD ADVICE

In agreement with the dispositions of Act 230 of August 9th, 2008, we warn you that Article 27.250 of the Code of Insurances of Puerto Rico arranges for the following: "Any person who knowingly and with the intention to defraud present false information in an insurance request or, present, help or make present a fraudulent complaint for the payment of a loss or benefit, or present more than one claim for the same damage or loss, will incur in serious crime and if convicted, sanctioned by each violation with a fine no smaller than five thousands ($5,000) dollars, nor greater of ten thousand ($10,000) dollars or imprisonment by a fixed term of three (3) years, or both rulings. If aggravating circumstances mediate, the fines established could be increased up to a maximum of five (5) years; if extenuating circumstances mediate, it could be reduced a minimum of two (2) years.

IV. COORDINATION OF BENEFITS INFORMATION

If you or any of your dependents are covered by another health insurance, please provide the information requested in Section B OTHER PLAN INFORMATION (COORDINATION OF BENEFITS).

If you submit for reimbursement charges for services or supplies that have been partially paid or denied by other health insurance, including Medicare, you must include the Explanation of Benefits of the other insurance or Medicare and a copy of the denial letter, with detailed invoices of the services or supplies.

V. RELEASE OF INFORMATION

By joining this Medicare health plan, I acknowledge that MCS Classicare will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that MCS Classicare will release my information including my prescription drug event data to Medicare, who may release it for research and other purposes which follow all applicable Federal statutes and regulations. The information on this reimbursement form is correct to the best of my knowledge.

MCS Classicare is a product subscribed by MCS Advantage, Inc. MCS Classicare is an HMO plan with a Medicare contract. Enrollment in MCS Classicare depends on contract renewal. MCS Advantage, Inc. complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. MCS Advantage, Inc. cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo. MCS Advantage, Inc. 遵守適用的聯邦民權法律規定，不因種族、膚色、民族血統、年齡、殘障或性別而歧視任何人。 ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-866-627-8183 (TTY: 1-866-627-8182). ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-866-627-8183 (TTY: 1-866-627-8182). 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電1-866-627-8183 (TTY: 1-866-627-8182).

CAN_4220517E