**REQUEST FOR MEMBER REIMBURSEMENT FORM**

<table>
<thead>
<tr>
<th>Date:</th>
<th>Member Name:</th>
<th>Health New England ID Number: (Shown on the front of your ID Card)</th>
</tr>
</thead>
</table>

Member Address:

**Reimbursement is for (check each reimbursement you are requesting below):**

- **Fitness Center**
- **Weight Watchers®**
- **Acupuncture**
- **Over-the-Counter Items**
- **Activity Tracker** (Above limited to $150 per calendar year combined)

Service/Purchase Date(s):

Service/Purchase Location(s):

Fitness Center/Weight Watchers location, etc.

Amount Requested: $

*Health New England will only reimburse for the following Over-the-Counter Items: shower chairs, grab bars, raised toilet seats, automatic blood pressure cuffs, bathtub benches/stools and compression stockings. Labor costs associated with the installation of over-the-counter items are not reimbursable under this allowance.*

- **Dental Services** (limited to $250 per calendar year)

Service/Purchase Date(s):

Amount Requested: $

Provider Name/Dental Practice:

- **Wig** - if on or recently undergone chemotherapy (limited to $350 per calendar year)

Service/Purchase Date(s):

Amount Requested: $

**Please include Original Itemized Receipt and written statement from your doctor stating you are on or had chemotherapy. Also, include Proof of Payment in one of the following formats: canceled check (front and back), bank encoded front of check, credit card statement, or a credit card or cash register receipt.**

I certify that this information is true and accurate and that services were received and paid for in the amount requested and that I have not previously submitted for these services. I acknowledge that if any information on this form is misleading or fraudulent, my coverage may be canceled and I may be subject to criminal and/or civil penalties for false health care claims. I also understand that Health New England may request any additional information it deems necessary to verify that services were received and payment was made.

Member Signature:  

Signature required for payment

*Please see additional submission information on the back of this form.*
**Additional Submission Information:**

Health New England will reimburse you directly for the services that qualify under each allowance. Health New England will not send payment to the service provider. You should keep a copy of your completed form and any receipts submitted. Please allow 4 to 6 weeks for processing.

**NOTE:** Reimbursement requests for a prior year must be received by Health New England no later than March 31.

Once you have completed this form and attached all itemized paid receipts and documentation (where applicable), please mail the form and attachments to the below address for processing.

**Health New England Medicare Advantage**
Attn: Claims Department
One Monarch Place, Suite 1500
Springfield, MA 01144-1500

If you have any questions about the Additional Benefits Reimbursement Form or your additional benefits, please call Health New England Medicare Advantage Member Services at:

**(413) 787-0010** or toll-free **(877) 443-3314, TTY: 711.**

A representative is available 8:00 a.m. – 8:00 p.m., Monday through Friday (October 1 – March 31: 8:00 a.m. – 8:00 p.m., seven days a week).