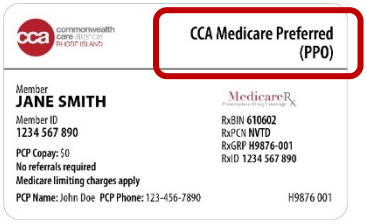
# REIMBURSEMENT INSTRUCTIONS

Please review these instructions carefully before submitting your reimbursement request. You must complete all fields on the form and attach required documentation.

**Commonwealth Care Alliance (CCA) Plan**
If you aren't sure which health plan you are enrolled in, check the top right-corner of your CCA member identification card. Members of all CCA plans (MA and RI) may use this form.





**Service Type**
Review your Evidence of Coverage/Member Handbook to confirm that the services or supplies you request reimbursement for are covered by your CCA health plan. If you are asking us to reimburse you for services or supplies that are not covered by your plan, your request may be denied. Refer to the attached chart for more information.

**Required Information**
We need your information to review your request. Be sure to include who you got services or supplies from and when you received them. Describe the services you received in detail. Refer to the attached chart for more information.

For transportation reimbursements: Include the date, the name of the provider you visited, and full addresses of the pick-up and drop-off locations.

**Proof of Payment**
You must include a copy of the receipt and an itemized bill of services or supplies. Receipts must show:

- Place and date of purchase
- Total amount paid and payment method
- Items/services to be reimbursed
- For services: service provider and date of service

The receipt or bill should include diagnostic and procedure codes. If an itemized bill is not available, you can submit a statement from the provider/supplier on their letterhead. Both your receipt and your itemized bill must be easy to read. CCA will not honor reimbursement requests for items purchased with gift certificates, gift cards, or pre-paid debit cards. CCA will not reimburse for coupons.

Modified February 2022

<table>
<tr><th>Service Type</th><th>Example</th><th colspan="2">Coverage Massachusetts Plans</th><th>Coverage Rhode Island Plans</th></tr>
<tr><td>Medical and Behavioral Health Services</td><td>Paid out-of-pocket for a doctor’s visit.</td><td colspan="3">Medical services paid for out-of-pocket must be covered by your plan to be eligible for reimbursement. See Member Handbook or Evidence of Coverage for detailed information about your covered benefits.</td></tr>
<tr><td>Dental</td><td>Paid out-of-pocket for replacement dentures.</td><td colspan="3">Dental services paid for out-of-pocket must be covered by your plan to be eligible for reimbursement. See Member Handbook or Evidence of Coverage for detailed information about your covered benefits.</td></tr>
<tr><td>Equipment and Supplies</td><td>Paid out-of-pocket for a cane.</td><td colspan="3">Medical equipment/supplies paid for out-of-pocket must be covered by your plan to be eligible for reimbursement. See Member Handbook or Evidence of Coverage for detailed information about your covered benefits.</td></tr>
<tr><td>Worldwide Emergency Services</td><td>Paid out-of-pocket for an emergency room visit in the Dominican Republic.</td><td colspan="3">Worldwide emergency services paid for out-of-pocket must be covered by your plan to be eligible for reimbursement. See Member Handbook or Evidence of Coverage for detailed information about your covered benefits.</td></tr>
<tr><td rowspan="4">Caregiver Support</td><td rowspan="4">A caregiver went with you to a doctor’s visit.</td><td>CCA Senior Care Options<br>Not covered.</td><td rowspan="2">CCA Medicare Maximum<br>Not covered.</td><td rowspan="2"></td></tr>
<tr><td>CCA One Care<br>Not covered.</td></tr>
<tr><td colspan="2">CCA Medicare Preferred<br>Not covered.</td><td></td></tr>
<tr><td colspan="3">CCA Medicare Value<br>See Evidence of Coverage for reimbursement amounts. Proof of payment is not required for caregiver support reimbursement requests.</td><td></td></tr>
</table>

Find your Evidence of Coverage/Member Handbook on our website or call CCA Member Services, 8 am to 8 pm, 7 days a week, from October 1 to March 31. (April 1 to September 30: 8 am to 8 pm, Monday to Friday, and 8 am to 6 pm, Saturday and Sunday.)

**CCA Massachusetts members: 866-610-2273 (TTY 711)** www.ccama.org **CCA Rhode Island members: 833-346-9222 (TTY 711)** www.ccari.org

<table>
<tr><th>Service Type</th><th>Example</th><th>Coverage Massachusetts Plans</th><th>Coverage Rhode Island Plans</th></tr>
<tr><td rowspan="4">Healthy $avings<br>Medicare-approved over-the-counter (OTC) items</td><td rowspan="4">Paid out-of-pocket for Tylenol.</td><td>CCA Senior Care Options<br>Healthy $avings items paid for out-of-pocket must be covered by your plan to be eligible for reimbursement. See Evidence of Coverage for detailed information about your covered benefits.</td><td rowspan="2">CCA Medicare Maximum<br>Healthy $avings items paid for out-of-pocket must be covered by your plan to be eligible for reimbursement. See Evidence of Coverage for detailed information about your covered benefits.</td></tr>
<tr><td>CCA One Care<br>Not covered.</td></tr>
<tr><td colspan="2">CCA Medicare Preferred<br>Healthy $avings items paid for out-of-pocket must be covered by your plan to be eligible for reimbursement. See Evidence of Coverage for detailed information about your covered benefits.</td></tr>
<tr><td colspan="2">CCA Medicare Value<br>Healthy $avings items paid for out-of-pocket must be covered by your plan to be eligible for reimbursement. See Evidence of Coverage for detailed information about your covered benefits.</td></tr>
<tr><td rowspan="4">Fitness/ Wellness</td><td rowspan="4">Paid out-of-pocket for services like:<ul><li>Health club or fitness facility membership fees</li><li>Fitness classes</li><li>Weight management program</li><li>Activity tracker (e.g. Fitbit)</li><li>Memory fitness activity</li><li>Approved wellness program</li></ul></td><td>CCA Senior Care Options<br>See Evidence of Coverage for reimbursement amounts.</td><td rowspan="2">CCA Medicare Maximum<br>See Evidence of Coverage for reimbursement amounts.</td></tr>
<tr><td>CCA One Care<br>Not covered.</td></tr>
<tr><td colspan="2">CCA Medicare Preferred<br>See Evidence of Coverage for reimbursement amounts.</td></tr>
<tr><td colspan="2">CCA Medicare Value<br>See Evidence of Coverage for reimbursement amounts.</td></tr>
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<tr><th>Service Type</th><th>Example</th><th>Coverage Massachusetts Plans</th><th>Coverage Rhode Island Plans</th></tr>
<tr><td rowspan="4">Transportation</td><td rowspan="4">Paid out-of-pocket for a taxi ride to and from a doctor’s office.<br><br>Note: Include all trip information on your reimbursement form, including: date, the name of the provider you visited, and full addresses of the pick-up and drop-off locations.<br><br>Example: Ride to Dr. Mary Roberts. From 123 North St., Boston, MA to 345 Main St., Boston, MA.<br><br>Ride home from Dr. Mary Roberts. From 345 Main St., Boston, MA to 123 North St., Boston, MA.</td><td>CCA Senior Care Options<br>One reimbursement per member per lifetime for rides to a covered destination.</td><td rowspan="2">CCA Medicare Maximum<br>Not covered.</td></tr>
<tr><td>CCA One Care<br>One reimbursement per member per lifetime for rides to a covered destination.</td></tr>
<tr><td colspan="2">CCA Medicare Preferred<br>Not covered.</td></tr>
<tr><td colspan="2">CCA Medicare Value<br>50% coinsurance, up to the maximum reimbursement amount. See Evidence of Coverage for reimbursement amounts. Example: If your maximum reimbursement is $32:<ul><li>If you pay $24 for a ride, then you will get $12 back.</li><li>If you pay $80 for a ride, then you will get $32 back.</li></ul></td></tr>
<tr><td rowspan="4">Delivered Meals</td><td rowspan="4">A CCA in-network provider delivered meals to your home after you returned home from a hospital stay.</td><td>CCA Senior Care Options<br>Not covered.</td><td rowspan="2">CCA Medicare Maximum<br>Not covered.</td></tr>
<tr><td>CCA One Care<br>Not covered.</td></tr>
<tr><td colspan="2">CCA Medicare Preferred<br>Not covered.</td></tr>
<tr><td colspan="2">CCA Medicare Value<br>50% coinsurance, up to the maximum reimbursement amount. See Evidence of Coverage for reimbursement amounts. Example: If your maximum reimbursement amount is $6:<ul><li>If you pay $10 per meal, you will get $5 per meal back.</li><li>If you pay $15 per meal, you will get $6 per meal back.</li></ul></td></tr>
</table>

# REIMBURSEMENT FORM

Submit this form with proof of payment to request reimbursement for out-of-pocket expenses.

**Mail:** Commonwealth Care Alliance Member Services Department
30 Winter Street, Boston, MA 02108
**Fax:** 617-426-1311 **Email:** memberservices@commonwealthcare.org

## CCA Plan

Please select the CCA health plan that you are a member of:

☐CCA Senior Care Options ☐CCA One Care ☐CCA Medicare Maximum
☐CCA Medicare Preferred ☐CCA Medicare Value

## Service Type

Please select which service or item you request reimbursement for:

☐ Medical/Behavioral Health ☐ Dental ☐Equipment/Supplies
☐ Worldwide Emergency Services ☐ Transportation* ☐ Healthy $avings
☐ Fitness/Wellness ☐ Caregiver Support** ☐ Delivered Meals

***Proof of payment not needed.*

## Required Information

Last Name: _____ First Name: _____ Middle Initial: ___

Member ID: _____ Date of Birth: _____ / _____ / _____

Service/Supply Provider: _____ Date(s) of Service: _____

**Use reverse side or another sheet of paper to include any additional information if needed.**

Describe the service or items that were received. **For transportation, include all trip information.*
*Example: Dr. Mary Roberts visit. Ride from 123 North St., Boston, MA to 345 Main St., Boston, MA*

_____

## Proof of Payment

Please include proof of payment AND an itemized receipt. Select your proof of payment:

☐ Receipt with itemized bill ☐ Receipt with statement on letterhead.

## Signature is Required

I attest that the information is accurate and complete:

Signature: _____ Date: _____