REIMBURSEMENT INSTRUCTIONS

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

Service Type
Review your Evidence of Coverage 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. Please refer to the attached table for examples of the types of reimbursements available.

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. Your healthcare provider can provide you with the CPT/diagnosis code needed for medical and behavioral services, dental, worldwide emergency services, equipment, or supplies. Describe the services you received in detail.

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 coupons.

Common reimbursement scenarios

Service Type	Example
Medical and Behavioral Health Services	Paid out-of-pocket for an office visit with a provider.
Dental	Paid out-of-pocket for replacement dentures.
Equipment/Supplies[1]	Paid out-of-pocket for a cane.
Worldwide Emergency Services	Paid out-of-pocket for an emergency room visit while traveling in the Dominican Republic.
Healthy Savings Card	Paid out-of-pocket for Tylenol purchased at a pharmacy.

[1] CCA may require prior authorization and/or a prescription for certain devices and equipment as a condition of payment. Refer to your Evidence of Coverage or Member Handbook for your plan's guidelines.

Commonwealth Care Alliance (CCA) is an organization that contracts with both Medicare and Medicaid to provide benefits of both programs to enrollees. Enrollment in a CCA health plan depends on contract renewal.

You can get this document for free in other formats, such as large print, braille, or audio. Massachusetts members, call 866-610-2273. Rhode Island members, call 833-346-9222. TTY users call 711. We are open 8 am to 8 pm, 7 days a week. The call is free.

ATENCIÓN: Si habla español, dispone de servicios gratuitos de asistencia lingüística. Los afiliados de Massachusetts deben llamar al 866-610-2273 (TTY 711), los afiliados de Rhode Island al 833-346-9222 (TTY 711).

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 health plan that you are a member of:

☐ CCA Senior Care Options ☐ 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 Services ☐ Healthy Savings

Required Information

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

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

Service/Supply Provider: _____

Date(s) of Service: _____ CPT/Diagnosis code: _____

Describe the service or items that were received:

_____

_____

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

Proof of Payment

Please include proof of payment (receipt) 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: _____