MEMBER REIMBURSEMENT FORM
One Care

Commonwealth Care Alliance®'s One Care program allows members to seek reimbursement for out-of-pocket medical expenses related covered OneCare services. To submit a request for reimbursement, please complete this form and all of it's pages following the provided instructions. This form must be submitted with a copy of a receipt that identifies the date of service/purchase and the product and/or services provided.

Service Type

Please check which service you are requesting reimbursement for:

☐ Medical ☐ DME ☐ Dental ☐ Vision ☐ Over the Counter with prescription (OTC)

Required Information

Last Name:_____ First Name:_____ Middle Initial: ____

Member ID #: _____ Date of Birth: __ / ___ / _____

(M M / D D / Y Y Y Y)

Name of Provider of Service:_____ Date(s) of Service:_____

Phone Number and Address of Provider (if known):_____

In what setting did you receive treatment? (e.g. office, ER, hospital, etc.) _____

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

Amount of reimbursement you are requesting: $_____

Describe the items or services that were received. (e.g. asthma, lab work, ER visit, flu shot, eyewear, durable medical equipment, etc.)

_____

Proof of Payment (Please include Proof of Payment AND Itemized Receipt)

Check which of the following acceptable proof of payment you are attaching to this form:

☐ A credit card statement or receipt with itemized bill.

☐ A copy of receipt with itemized bill.

☐ A statement from the provider, on the provider's letterhead with authorized signature, indicating payment was made.

Submission Method

To submit your request for reimbursement, please send this form and related documents to:

By mail: Commonwealth Care Alliance Attn: Member Services, 30 Winter Street, Boston, MA 02108

By fax (617) 426-1311

By email memberservices@commonwealthcare.org

Signature is Required

I attest that the information is accurate and complete.

Signature:_____Date:_____

Notice of Nondiscrimination

Commonwealth Care Alliance complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Commonwealth Care Alliance does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Commonwealth Care Alliance:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Civil Rights Coordinator.

If you believe that Commonwealth Care Alliance has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Civil Rights Coordinator, Office of General Counsel
30 Winter Street
Boston, MA 02108
Phone: 1-617-960-0474, ext. 3932, (TTY: 711)
Fax: 1-617-249-0709
E-mail: civilrightscoordinator@commonwealthcare.org

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Multilanguage Interpreter Services

English: ATTENTION: If you speak another language, language assistance services, free of charge, are available to you. Call 1-866-610-2273 (TTY: 711).
Spanish (Español): ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-866-610-2273 (TTY: 711).
Chinese (繁體中文)：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 1-866-610-2273（TTY：711）。
Tagalog (Tagalog – Filipino): PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-866-610-2273 (TTY: 711).
French (Français): ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-866-610-2273 (ATS: 711).
Vietnamese (Tiếng Việt): CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-866-610-2273 (TTY: 711).
German (Deutsch): ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-866-610-2273 (TTY: 711).
Korean (한국어): 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-866-610-2273 (TTY: 711)번으로 전화해 주십시오.
Russian (Русский): ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-866-610-2273 (телетайп: 711).
Arabic (العربية): ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 3722-016-668-1 (رقم هاتف الصم والبكم: 117).
Hindi (हिंदी): ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-866-610-2273 (TTY: 711) पर कॉल करें।
Italian (Italiano): ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-866-610-2273 (TTY: 711).
Portuguese (Português): ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-866-610-2273 (TTY: 711).
French Creole (Kreyòl Ayisyen): ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-866-610-2273 (TTY: 711).
Polish (Polski): UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-866-610-2273 (TTY: 711).
Greek (λληνικά): ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε 1-866-610-2273 (TTY: 711).
Japanese (日本語)：　注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1−866−610−2273（TTY:711）まで、お電話にてご連絡ください。
Cambodian (ខ្មែរ): ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-866-610-2273 (TTY: 711)។
Lao/Laotian (ພາສາລາວ): ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-866-610-2273 (TTY: 711).
Gujarati (ગુજરાતી): સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-866-610-2273 (TTY: 711).