Medicare Advantage Hearing Aid Reimbursement Form

- Please use this form for reimbursement of your $600 Hearing Aid benefit.
- Reimbursement forms must be received no later than one year after the date you paid for the service.
- Please PRINT. For more information about completing the form, see the reverse side.

Member Information (for the specific member using this benefit):

Health Plan ID #: Ex: 820000000-00	8										

Member's Last Name:	First Name:	Middle Initial:	Date of Birth:

Address:	City/State/Zip Code:	Phone Number:

Service Provider Information – NPI 1999999984:

Name, address, phone number of service provider:	
Tax Identification Number of service provider:	

Total number of receipts attached:		Place of Service:	11

Purchase Date:	Diagnosis Code:	Type of Service:	Amount Paid:
	3899 (valid for services until 9/30/2015) H9190 (Valid for services 10/01/2015 and beyond)	Hearing Aid – V5130	

Certification and Authorization: (this form must be signed below)
I authorize the release of any information to MVP Health Care about my hearing aid utilization. I certify that the information provided in support of this submission is complete and accurate. It has not and will not be submitted for reimbursement under any other health plan coverage (such as a Flexible Spending Account).

____________________________________ __________________

Subscriber's signature **Date**

Any person who knowingly files a reimbursement request containing any misrepresentation or any false, incomplete or misleading information is guilty of a criminal act punishable under law and may be subject to civil penalties.

Return to: MVP Health Care, Medicare Advantage Hearing Aid Reimbursement, P.O. Box 2207, Schenectady, NY 12301. ***(See reverse for guidelines on completing this form.)***

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How to Submit Your Hearing Aid Reimbursement Request
In order to process your request promptly, please refer to the following guidelines to ensure that all necessary information is included.

1. This form may be used by MVP Medicare Advantage members when submitting a reimbursement request for your Hearing Aid benefit. This benefit is provided to each member. A separate form must be completed for each eligible member of your household.
2. All reimbursement forms must be received by MVP Health Care no later than one year after the date you paid for the service.
3. Attach the pre-printed, paid original receipt showing the type of service:
   - You must pay for the service before submitting a request for reimbursement.
   - For each item you are requesting, you must attach a copy of itemized bills, statements or receipts pre-printed or stamped or on company letterhead with the service provider's name and address.
   - Balance forward/prior balance statements are not acceptable.
   - Your claim form must include the following information:
     - Your name and MVP member ID number
     - The name and address of the provider
     - The provider tax identification number
     - The type of service provided
     - The date of purchase
     - Your out-of pocket cost for the service
   - **Please note:** reimbursement requests that are not submitted according to these guidelines will be returned for you to correct and re-submit.
4. MVP Health Care reserves the right to refuse reimbursement if the service provider does not meet benefit and quality standards as determined by MVP Health Care.
5. Sign this form and return it to: MVP Health Care
   Medicare Advantage Hearing Aid Benefit
   P.O. Box 2207
   Schenectady, NY 12301
6. Please allow 4-6 weeks for reimbursement (as long as your request is complete and accurate).
7. Please visit our website at www.mvphealthcare.com for more information about your Hearing Aid benefit.

MVP Health Care is dedicated to prompt and accurate reimbursements to our health plan participants. By following these instructions and filling out the reimbursement form completely, you will help us process your request in a satisfactory manner. Thank you!