Prominence
Medicare Advantage

Prominence Health Plan Medicare Advantage Direct Member Reimbursement Form

Please read the instructions below, then proceed to fill out the Reimbursement Form for Medicare Advantage members.

Mailing Instructions

Please keep copies of all documentation when sending in your Reimbursement Form.

Please enclose copies of the following:

- A copy of your receipt and a completed Reimbursement Form

Mail to:
Prominence Health Plan
Claims Department
1510 Meadow Wood Lane
Reno, NV 89502
Fax: 775-770-9363

Frequently Asked Questions and Answers

How do I qualify for a reimbursement?

- You must be a Prominence Health Plan Medicare Advantage member.
- Your coverage must be **active** as of the date on the receipt provided with this Reimbursement Form.
- Reimbursement is for **current** Prominence Health Plan Medicare Advantage members. This benefit may not be used to purchase for anyone other than yourself (the member).

When can I submit my Reimbursement Form?

- You may submit a Reimbursement Form anytime during the plan year. The reimbursement is dependent upon the benefits outlined in your Evidence of Coverage (EOC).

How much can I claim for reimbursement?

- Please review your EOC for complete details regarding the maximum annual reimbursement for this benefit. Subject to available funds.

What happens once I submit my reimbursement?

- Request will be reviewed
  - Approved – Notification will be sent.
  - Denied – Notification will be sent.

- Reimbursement checks will be mailed and made payable to the member only at the member's address of record. No alternative address will be accepted.
- If you believe your current address is different than the address of record with Prominence Health Plan, please contact the Care Advocate team prior to submitting your Reimbursement Form.
- Please allow 6-8 weeks for processing.

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To be filled out by a Prominence Health Plan Medicare Advantage member only. Please use blue or black ink and **print** all information clearly.

When to submit this form:

- **After** your service or purchase *was completed.*
- **After** you verify that you had coverage with Prominence Health Plan at the time of purchase.
- Once all sections have been completely filled out and signed by the member.

Section A – Member & Reimbursement Information

____
Member ID#

____
Member Last Name First Name Middle Initial

____
Address

____
City State Zip Code

____
Daytime Phone (area code) xxx-xxxx E-mail Address

	Type of Request (Circle)	**City, State**	**Phone Number**	**$ Being Claimed**
Date: ___/___/__	• **Hearing** • **Vision** • **Dental** • **Claim**			

Total number of documents_____ **Total dollar amount being claimed $__________**

Section B – Member Certification

I certify that the information on the form and all supporting documents is complete, accurate and unaltered.

____
Member Signature Date