

GEISINGER GOLD

Geisinger

Please use this form only to request reimbursement for covered services you have received

MEMBER INFORMATION:

PLEASE PRINT LEGIBLY

Member ID Number:

Date of Birth:

/ /

Name:

Last

First

MI

Address:

Street

City

State

Zip Code

Check if new address:

HAVE YOU REQUESTED REIMBURSEMENT FOR THIS CLAIM(S) FROM ANYONE OTHER THAN GHP?

YES

NO

**SUPPLEMENT REIMBURSEMENT
REQUEST INFORMATION:**

Receipts **MUST** be attached or your reimbursement will be denied

DENTAL

(Out-of-network
services only)

VISION

FITNESS

(Out-of-network
services only)

Consult your Evidence of Coverage for benefit details and coverage limits.

PLEASE SIGN AND DATE BELOW:

I certify that all information listed above is correct for myself or members of my family who are eligible. I have received the services above and authorize release of all information contained on this claim to my plan sponsor.

MEMBER SIGNATURE

DATE

Please see important information on reverse

PREFERRED 360

A SEPARATE FORM MUST BE COMPLETED FOR EACH MEMBER

MEMBER SUPPLIED INFORMATION:

1. You **MUST** attach an itemized receipt to your reimbursement form that provides the following information:
 - a. Provider name
 - b. Date of service
 - c. Description of service or item received
 - d. Amount billed
 - e. Amount paid
2. Please print the requested information
3. Print member's ID number (found on your insurance card)
4. Print member's date of birth in the mm/dd/yyyy format
5. Print member's name, first, last, middle initial or as it appears on your insurance card
6. Print member's full address including city, state, and zip code
7. Check the box if this is a new address
8. Indicate if you are seeking other reimbursement for the reimbursement you are submitting

IMPORTANT:

1. The member must sign and date each form to be eligible for reimbursement
2. Completion and submission of this form does not guarantee requested reimbursement
3. Incomplete or missing information could cause a delay in processing
4. Claims processing can take up to 45 days

QUESTIONS?

Call Geisinger GOLD Member Services at 800-498-9731

PLEASE RETURN THIS REIMBURSEMENT FORM TO:

Geisinger Health Plan
P O BOX 853910
Richardson, TX 75085-3910

DID YOU SIGN AND DATE THE FRONT OF THIS REIMBURSEMENT FORM?

Any person knowingly and with intent to defraud any insurance company or other person files an application for insurance or state claim containing materially false information or conceals for the purpose of misleading, information concerning any material fact thereto commits a fraudulent insurance act, which is a crime and is subject to criminal and civil penalties

Geisinger Gold Medicare Advantage HMO, PPO, and HMO D-SNP plans are offered by Geisinger Health Plan/Geisinger Indemnity Insurance Company, health plans with a Medicare contract. Continued enrollment in Geisinger Gold depends on contract renewal. Geisinger Health Plan/Geisinger Indemnity Insurance Company are part of Geisinger, an integrated health care delivery and coverage organization.