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

PLEASE READ THE FOLLOWING INSTRUTIONS CAREFULLY AND FILL OUT THE FRONT SIDE OF THIS FORM

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?