

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



**MEMBER INFORMATION** PLEASE PRINT LEGIBLY

<b>Member ID Number:</b>				Date of Birth: / /	
<b>Name:</b>		Last		First	
<b>Address:</b>		Street		City	
		State		Zip Code	

Check if new address:

HAVE YOU REQUESTED REIMBURSEMENT FOR THIS CLAIM(S) FROM ANYONE OTHER THAN GHP?  
 YES  NO

<b>SUPPLEMENT REIMBURSEMENT REQUEST INFORMATION:</b>	Receipts <b><u>MUST</u></b> be attached or your reimbursement will be denied					
Geisinger Gold Plan Name	DENTAL SERVICES	ROUTINE EYEWEAR	EYE EXAM (ROUTINE)	FITNESS	HEARING AID(S)	HEARING EXAM (ROUTINE)

	Indicate dollar amount of request under specific benefit supplemental benefit					
Geisinger Gold Secure Rx (HMO DSNP)	\$	\$	Not Applicable	Not Applicable	Not Applicable	Not Applicable
Geisinger Gold Classic 360 Rx (HMO)	\$	\$	\$	Not Applicable	Not Applicable	Not Applicable
Geisinger Gold Classic Advantage Rx (HMO)	\$	\$	\$	\$	Not Applicable	Not Applicable
Geisinger Gold Classic Complete Rx (HMO)	\$	\$	\$	\$	Not Applicable	Not Applicable
Geisinger Gold Classic Essential Rx (HMO)	Not Applicable	Not Applicable	Not Applicable	Not Applicable	Not Applicable	Not Applicable
Geisinger Gold Heritage (HMO)	\$	\$	\$	\$	Not Applicable	Not Applicable
Geisinger Gold Value Rx (HMO)	\$	\$	\$	Not Applicable	Not Applicable	Not Applicable
Geisinger Gold Preferred Advantage Rx (PPO)	\$	\$	\$	\$	\$	\$
Geisinger Gold Preferred Complete Rx (PPO)	\$	\$	\$	\$	\$	\$

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

<b>PLEASE SIGN AND DATE BELOW:</b>	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
MEMBER SIGNATURE	
DATE	

## 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 reimbursement from insurance other than Geisinger Health Plan

### 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 160

Glen Burnie, MD 21060

## 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 of 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.  
revised:11/18/2025