Out of Area & Out-of-Network Pharmacy Reimbursement Request

(see instructions on reverse side)

CHRISTUS Health Plan

US FAMILY HEALTH PLAN
Caring for our Uniformed Services Family

A. Sponsor/Member Information

*Member Name: _____

*Member Date of Birth: _____ *Member ID Number: _____

*Sponsor Name: _____ *Group Name: _____

B. Service Information

*Name of health care provider (physician, facility, pharmacy, etc.): _____

*Date(s) of service: _____ *Amount paid for service: _____

*List the illness or injury(s) requiring treatment: _____

*Was the illness or injury due to an accident? _____

If yes, provide the date of accident: _____

*Did your accident require hospitalization? _____

If yes, provide the hospital name and address: _____

*Was this a work-related injury or illness? _____

If yes, provide the name and address of your employer: _____

C. Other Health Insurance Coverage

*Do you have other health insurance coverage? _____

If yes, provide the following information:

Insurance name and address: _____

Subscriber name and address: _____

Subscriber ID number: _____

Group number: _____

Please sign and date below. If signature is not provided, this claim will be denied as unable to process.

Print Name: _____

Signature: _____ **Date:** _____

**Denotes required field. Determination may be delayed if these fields are not filled out.

REIMBURSEMENT OF OUT-OF-POCKET EXPENSES FOR OUT-OF-AREA SERVICES

If you are traveling outside the service area and require urgent or emergent care, the provider should bill USFHP at the address shown on the back of your Member ID card. However, some providers (especially if they are outside the United States) may require immediate payment from you.

To obtain reimbursement for Out-of-Area services as described above, you must submit this completed form and the required documentation within 365 days of the date of service, at the address indicated below. Requests submitted after 365 days will be denied.

REIMBURSEMENT OF COVERED OUT-OF-NETWORK PRESCRIPTION DRUGS

The Point of Service (POS) benefit applies to covered prescription drugs filled at out-of-network pharmacies when prescribed by an authorized US Family Health Plan provider. Please note: The POS benefit has a higher out-of-pocket cost for covered prescription drugs than if you had chosen an in-network pharmacy. (50% of total cost applies after the POS deductible is met for formulary and non-formulary covered drugs)

To obtain reimbursement for covered out-of-network prescription drugs you must submit this completed form and the required documentation within 365 days of the date the prescription was filled, at the address indicated below. Requests submitted after 365 days will be denied.

SUBMISSION ADDRESS FOR REIMBURSEMENT

Submit this completed form and the required documentation within **365 days of the date of service,** at the address indicated below:

CHRISTUS Health Plan
Attn: Claims Department
919 Hidden Ridge
Irving, TX 75038

INSTRUCTIONS TO FILL OUT REIMBURSMENT FORM

Please complete the reimbursement request form as directed below:

1. **Complete Section A:** Enter/write Sponsor/Member Number as printed on the US Family Health Plan membership ID card.
2. **Complete Section B:** Enter/write the name of the physician, facility, pharmacy or other health care professional from whom you received services; the date of the service; and the amount you paid. Provide as much information as possible. If you need assistance in completing, please call Member Services at the number on the back of your Member ID card.
3. **Complete Section C:** If applicable, enter/write the name and address of your other health insurance, as well as, the additional requested information for your policy. In the event that you are submitting multiple requests for reimbursement, this section can be filled out only one time unless there is change that needs to be noted.
4. **Attach Evidence of Payment:** Attach copy of original receipt or cancelled check **and** a copy of your bill.

Important Note: If this form and required documents are not included the claim will be denied due to lack of documentation. It could take up to 30 days for your request to be uploaded and processed into CHRISTUS systems. (Upload could take even longer if additional research is required for your submission.) Appeals should not be submitted until you receive a determination letter for this service from the plan.

If you have additional questions regarding your benefits, please contact member services at the number on the back of your member ID card or review the member handbook, which can be accessed online at christushealthplan.org.