new mexico health connections

Member Medical Claim Reimbursement Form

Claim Filing: Please make sure you and your physician or health care professional complete this form in its entirety in order to receive timely reimbursement for covered medical services.

Member Information

Patient Name:	**Patient ID Number:**	
Subscriber Name:	**Patient Date of Birth:**	**Patient Phone Number:** ( )
Address:		
City:	**State:**	**Zip Code:**

Provider Information

Provider Name:		
Provider Phone #:	**Provider TIN/NPI Number:**	
Provider Address:		
City:	**State:**	**Zip Code:**

Billing/Claim Information

Payment Authorization: I authorize payment directly to the healthcare providers indicated on the enclosed bill for Medical Benefits otherwise payable to me for services rendered by them.

☐ **If yes, please check box and sign: _____**

Place of Service: Please check one:	☐ Doctor's Office ☐ Hospital (Inpatient) ☐ Hospital (Outpatient)	☐ Urgent Care/Emergency ☐ Other Health Care Professional (Durable Medical Equipment, Lab, etc.)

Date of Service:				**Total Paid:**			
Diagnosis Code:	**1.**		**2.**		**3.**		**4.**

CPT/HCPCS/REV Code:	Procedure, Medical Services, or Supplies Description	Number of Services/Units	Charges

I certify that the above statements are true and correct. ☐	**Signature:**	**Date:**

Instructions for Filing a Member Reimbursement Claim

- Type or print requested information when completing the form.
- A separate member reimbursement request form must be completed for each patient, by each provider.
- Do not submit a form if your physician or other health care professional is also filing a claim to NMHC for the same service.
- Attach itemized statement, itemized receipt or claim form for each service.
- Attach explanations of benefits from other primary insurance carriers, if applicable.
- Please keep photocopy of each itemized bill or receipt for your records. Receipts will not be returned.
- All foreign claims much be translated, and currency must be converted to U.S. dollars.
- Claims must be filed within 1 year (365 days) from the date of service.
- Claims form must be signed and dated by the member, patient, or responsible party.

Member Benefit Information

Copayments, deductibles, coinsurance, and non-covered services will be patient responsibility.

If you receive care from an out-of-network provider and the provider bills more than the Usual, Reasonable, and Customary charge, the member will be responsible for the sum of the co-insurance amount and any amount that is over the Usual, Reasonable and Customary charge.

If all information has been correctly submitted you can expect your claim to be processed within 30-45 business days of receipt by NMHC. THIS IS NOT A GUARANTEE OF PAYMENT. Actual payment for covered service will be paid at the appropriate level according to your plan benefits.

CONTACT AND MAILING INFORMATION

For questions or assistance, please call New Mexico Health Connections Customer Care Department at **1-855-769-6642**.

Send this Member Medical Claim Reimbursement Form to:
New Mexico Health Connections
P.O. Box 211468
Eagan, MN 55121

Or fax to: 1-312-548-9943