univera HEALTHCARE

For Internal Use

Medicare Advantage Flex Card Reimbursement Form

This form should be used to request reimbursement for eligible dental, vision and hearing services you have received without using your plan provided flex card. Any reimbursement will be deducted from the account balance on your flex card. The total reimbursement is limited to the available amount on your flex card at the time of submission.

Member Information:

Univera Healthcare Member ID: _____

Member Last Name: _____ Member First Name: _____

Street Address: _____

City, State ZIP: _____

Contact Phone Number: _____ Date of Birth: _____

Dental, Vision or Hearing Claim Information:

Date of Service	Provider Name	Item Purchased	Expense Amount
		Grand Total	

For each claim, please:

- **Include an itemized bill that shows each item being requested for reimbursement**
- Be sure the bill lists the member & provider name and address, date of service, description of service provided and charge for each service

Member Statement of Understanding

My signature below certifies the following:

- I understand that I can only be reimbursed for items that are a covered benefit under my plan.
- I certify that the purchases are for my personal use only.
- I certify that these items were not covered under any other plan or program.
- I certify that the above information is true, and the enclosed material is correct and unaltered, and the expenses were incurred by the patient. I understand all material submitted becomes the property of Univera Healthcare and will not be returned. I realize false receipt or fraudulent alterations of these materials will result in civil or criminal prosecution. I authorize the release of any information.

Member Signature: _____ Date: _____

All signatures (electronic, digital and /or handwritten) are legally binding and enforceable .

Mail to: Claims Dept., PO Box 211254, Eagan, MN 55121

The expenses you submit must qualify as dental, vision or hearing covered benefits in order to qualify for reimbursement. Please consult your Evidence of Coverage for a description of covered benefits.

Your Evidence of Coverage can be found at **MyUniveraMedicare.com** under **Resources > Evidence of Coverage.** Please reference the Plan name on your ID card to be sure you locate the correct Evidence of Coverage.

- Please complete all fields on the claim form (Providing you Phone Number and E-mail are optional).
- List each item individually in the table. Do not "lump" or group items together.
- If you have more items than can fit on the form, please use an additional form.
- Please be sure to include a detailed bill that shows each item being requested for reimbursement.
- Handwritten receipts are not accepted.
- Keep a copy of all forms and receipts for your records.
- You have 180 days after the end of the calendar year in which your expense was incurred to submit your claim for reimbursement.
- This form should not be E-mailed, Please mail to the address provided below

Mail to: Claims Dept.
PO Box 211254
Eagan, MN 55121

Call: Customer Care with questions at 1-877-883-9577 (TTY: 1-800-662-1220) Monday to Friday, 8 a.m. to 8 p.m. Extended hours offered October 1 to March 31 only. We are available 7 days a week, 8 a.m. to 8 p.m. during this time.

You may also file for a reimbursement through the member portal by following these instructions:

Login to your Medicare member account at **MyUniveraMedicare.com**.

Scroll down to see your Medicare Flex Card information

Click on **"File Claims, View Statements and More"**

Select **"Reimburse Myself"** from the Home Menu

Follow the prompts to complete your claim. *(Make sure you upload a copy of your receipt).*