



Medicare Duals Special Needs Plan OTC and Healthy Food Reimbursement Instructions

For Internal Use

This form should be used to request reimbursement for eligible Over-the-Counter (OTC) and Healthy Food items you have purchased without using your-plan provided flex card. Any reimbursement will be deducted from the account balance on your OTC & Healthy Food Flex card. The total reimbursement is limited to the available amount on your flex card in the month of the purchase.

Member Information:

Univera Healthcare Member ID: _____

Member Last Name: _____ Member First Name: _____

Street Address: _____

City, State ZIP: _____

Contact Phone Number: _____ Date of Birth: _____

OTC and Healthy Food Claim Information:

Purchase Date	Merchant Name	Item Purchased	Expense Amount
Grand Total			

For each claim, please:

- **Include an itemized receipt that shows each item being requested for reimbursement**
- Be sure the receipt lists the merchant address or URL (web address) for on-line vendors

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.
- If purchasing an item that requires the recommendation of a healthcare provider, I certify that I have discussed the necessity of this item with my provider.
- 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

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- The expenses you submit must qualify as OTC or Healthy Food 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](https://www.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 your 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 receipt 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 90 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 1-866-862-7087 (TTY: 1-800-662-1220) 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](https://www.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).

The Healthy Food benefit is part of a special supplemental program for the chronically ill. Not all members qualify.