

Member Reimbursement Medical Claim Form Help Sheet

(one per member per provider)

(Please print clearly when completing the medical claim form)

FIELD #	FIELD NAME	DESCRIPTION
1	Member's Tufts Health Plan # and Plan Type	ID# with suffix, found on the front of the Tufts Health Plan ID card.
2	Member's Name	Last, First, Middle Initial of patient who received services.
3	Member's Date of Birth Member's Sex	Date of Birth: Month (2 digits), Day (2 digits), Year (4 digits) Sex: M = Male, F = Female
4	Member Relationship to Subscriber	Is the member the subscriber, the spouse, the child or an other (e.g. partner)?
5	Subscriber's Name, address, and telephone #	Subscriber is the person: <ul style="list-style-type: none"> ▪ who enrolls in Tufts Health Plan and signs the membership application form on behalf of him/herself and any dependents ▪ in whose name the premium is paid. Subscriber's address must include zip code. Subscriber's telephone number must include area code.
6	Provider's Name, address, telephone #, license # and state of license	Fitness club information.
7	In what setting did the member receive treatment?	Fitness club
8	Outside the USA	If applicable, indicate in what country services were provided, in what language (if not English) the bill and proof of payment are written, and in what currency the bill was paid.
9	Diagnosis: What was the member seen for?	<ul style="list-style-type: none"> ▪ For non-mental health services, provide a procedure code or detailed description of the illness or injury.*
10A	Year of fitness club membership	The year of the fitness club membership.
10B	Procedures, Services, or Supplies Provided	<ul style="list-style-type: none"> ▪ For non-mental health services, provide a procedure code or detailed description.* (e.g.: wig, birthing class, etc.)
10C	Amount Paid	Amount paid for fitness club membership.
11	Total Amount Paid	Total amount for which you are requesting reimbursement.
12	Proof of Service(s)	A document (see Member Reimbursement Medical Claim Form) from the fitness club listing date(s) of service, service(s) provided, and dollar amounts paid.
13	Proof of Payment	A document (see Member Reimbursement Medical Claim Form) that confirms your payment.
14	Signature is Required	SIGNATURE OF INDIVIDUAL COMPLETING FORM MUST BE INCLUDED: By signing the Member Reimbursement Medical Claim Form, you are acknowledging that services were received and paid for in the amount requested.

*As with all medical treatments, please consult with the provider office for an accurate code/description.