Direct Member Reimbursement (DMR) Claim Form

This claim form is used by members to request reimbursement of covered expenses. This DMR Claim Form is not required to receive a reimbursement for your expenses. Check your plan materials to find out what expenses your plan will pay for.

If you have any questions as you prepare to submit a Direct Member Reimbursement, please call the toll-free number Customer Service number on the back of your ID card.

Please let us know the reason for your reimbursement request:

□ Traveled out of the country

□ Used a non-participating provider

□ Other

Explanation: _____

Customer Information

Member ID Number (from your Mass Advantage ID card): _____

Member Name: _____ Member Date of Birth _____

Member Address: _____

Contact Phone: _____

Doctor or Facility who provided the services

Name: _____

Address: _____

City_____ State_____ Zip _____

Phone Number _____

You will need to submit information on your doctor or facility bill

For each service you will need to submit a billing statement for the services received, and proof of payment, such as a paid receipt, invoice, or provider statement. This information must show:

- The service you received
- The cost of the service (billed amount)
- The amount you paid
- The date you paid
- Your payment type (check, credit card, etc.)

The specific medical information that is needed for each service is:

- The diagnosis or illness
- A description of what service was provided (example office visit, surgery, etc.)
- The number of services provided and the date of each service

Foreign travel

What country and country were you in when you received this medical care?

_____

What currency did they bill you? _____

What currency did you pay the? _____

If the provider invoice is in a foreign language, what is the language? _____

Signature

By signing and submitting this form, you certify that the information is true and correct.

_____ _____

Member or authorized representative signature Date

If an authorized representative is submitting this for you

If someone else is submitting this for you, please include the required Appointment of Representative (AOR), Power of Attorney or Executor of Estate form. The AOR form, instructions and option for a large print version can be found at: https://massadvantage.com/grievances-and-appeals/

MASS ADVANTAGE

Send your completed information

Please send your completed form and the billing statements/proof of payment the Medical Claim Address on the back of your member ID card.