Harvard Pilgrim Health Care
a Point32Health company

Stride℠ (HMO) and Stride (HMO-POS) Member Reimbursement Request Form

(Please use the Stride℠ Prescription Claim Form for Medicare Part D Reimbursement Requests)

Member Name:_____ **HPHC Member ID**: _____ **Stride℠ Plan Name:** _____

Address: _____ **Person Submitting Form:** ☐ **Member** ☐ **Provider** ☐ **Other** _____

City: _____ **Submitter Name:** _____ **Daytime Telephone:** _____

State/ZIP: _____ **Please specify the preferred benefit you would like to use for this reimbursement.***

Daytime Telephone: _____ ☐ **Wallet Benefit** ☐ **Medical Benefit** ☐ **Other** _____

*Benefits vary by plan. Please reference your Evidence of Coverage (EOC) for coverage information. Some benefits have dollar, timeframe or provider type limits. Requests must be submitted no later than 60 days after the end of the Plan year. Requests will be processed based on preference noted and benefit eligibility. Payments will be made to the member if not specified. You may be contacted if additional information is needed to process your request. Please allow up to 9 weeks for processing.

Item No.	Date of Service or Membership Date(s)	Provider Information (First, Last, Credentials (M.D., D. O., etc.)	Provider Daytime Telephone Number (area code + number)	Provider License Number (when applicable) #	Provider Service Address (Street, City/ Town, State, ZIP)	Pay to Member (M) or Provider (P)	Check if the Receipt/Bill is enclosed	Amount you paid to the provider or Amount Billed
						Total Amount		

For coverage of eligible acupuncture, massage therapy, holistic medicine, mind/body therapy or bodywork, the provider must be licensed at time of service.

If you have any questions, please visit www.harvardpilgrim.org/medicare or contact Member Services at 1-888-609-0692 (TTY: 711). Our representatives are available to assist you October 1 – March 31, 8 a.m. to 8 p.m., 7 days a week, and April 1 – September 30, 8 a.m. to 8 p.m., Monday through Friday.
If this form is submitted by an authorized representative, please also submit a signed Appointment of Representative form or other supporting documentation.
Please sign and mail to: Harvard Pilgrim Health Care, Stride℠ Member Reimbursements, P.O. Box 211067, Eagan, MN 55121

Member Signature: _____ **Date:** _____
I certify that the information on this form and all supporting documents enclosed are complete, accurate and unaltered.

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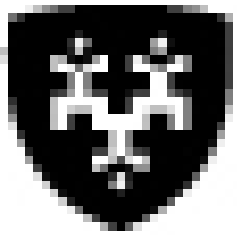

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