

Member Reimbursement Form Instructions

To make sure you are giving us all the information we need to make a decision, you can fill out the Member Reimbursement Form to make your request for payment. Please note that is not required to complete the Member Reimbursement form but it will help us process the information faster.

- The following information must be attached to this form or included with your request for payment. However, Sonder Health Plans may request additional documentation when necessary.
 - Copies of itemized statement from provider that show dates of service, place of service, diagnosis codes, procedure codes, units/days, and amount charged.
 - Copy of receipt with the provider's name and address preprinted.
 - Proof of payment that includes but is not limited to bank statements, front and back of cleared check written to provider, etc.
 - Copies of medical records supporting the services received.
- If the request is submitted by someone other than the member, he or she must submit a copy of the papers showing appointment as legal representative, such as a completed Appointment of Representative, Power of Attorney, Court Appointed Guardian or any other proof of legal representation. You can download a copy of the Appointment of Representative form at our website by accessing the following link [CMS-1696](#). If a person claims payment as the legal representative of a deceased member's estate, he or she must submit copy of the papers showing appointment, such as Executor of an Estate, Social Security Administration Survivor Benefits Eligibility letter or any other proof of legal representation.
- Members who received emergency care outside of the United States should follow up immediately with their Primary Care Physician. For further assistance, please contact Member Services department.
- Medical bills paid in a currency other than U.S. Dollar will be converted using the currency exchange rate for the country where services were rendered and the date the payment was made.
- After the form or request for payment is completed and supporting documentation is collected, please send all documents to the Claims Department at the address, email or fax listed below within **one (1) year** of the date of service. If you are unable to submit this form or request for payment and the additional documentation requested within the allowable timeframe; you must provide a letter of good cause for the delay.

Attention: Claims Department
6190 Powers Ferry Road, Suite 320
Atlanta, GA 30339

Fax number: (678) 813-5594 – Email: claims@sonderhealthplans.com

Any person who knowingly and with intent to injure, defraud, or deceive any insurer, files a statement of claim or an application containing any false or misleading information may be found guilty of a felony of the third degree.

Member Reimbursement Form

ONE FORM PER MEMBER/PER PROVIDER

Please print clearly, complete all sections and sign. Retain copy for personal records.

Member Information

Member Name:		Date of Birth:	
Primary Care Physician:		Member ID:	
Address:		City:	State:
		ZIP:	
Day Phone:	Evening Phone:	Requestor:	
		<input type="checkbox"/> Member <input type="checkbox"/> Member's Representative	

Provider/Billing Information

Provider Name:
Provider Address:
Provider Phone:
Provider Tax ID#:

Additional information: Complete any information that applies.

1. Was the above service(s) received because of an emergency?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
2. Was the condition above related to an auto accident?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
3. Were services above rendered out of the country?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
4. Did any other insurance company pay for services received? (i.e. travel insurance)	<input type="checkbox"/> YES	<input type="checkbox"/> NO
5. Was your primary care physician notified?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
6. Were you referred to the attending provider by your primary care physician?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
7. Is a copy of itemized statement included with this form?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
8. Is a copy of receipt included with this form?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
9. Is proof of payment included with this form?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
10. Are copies of medical records included with this form?	<input type="checkbox"/> YES	<input type="checkbox"/> NO

The following information must be obtained from your provider, or must be included on the itemized statement from your provider.

Dates of Service	Place of Service (Office, Emergency Room, Urgent, Hospital, Clinic, Ambulance, Home)	Diagnosis Code (DX)	Procedure Codes	Units/Days	Amount Charged in U.S. \$	Amount Paid in U.S. \$
Total:					\$	\$
If amount charged was originally in currency other than U.S. dollars, please indicate total charged amount below:			If amount paid was originally in currency other than U.S. dollars, please indicate total paid amount below:			
\$			\$			

Sonder Health Plans complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Sonder does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-844-430-1407. (TTY: 711). ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-844-430-1407. (TTY: 711) Sonder Health Plans is an HMO and PPO plan with Medicare contracts. Enrollment in Sonder Health Plans depends on contract renewal.

