VIBRA™ Health Plan

MEMBER CLAIM FORM

(please complete one form per provider)

INSTRUCTIONS

1. You may need your health care provider to assist and supply information in completing this form, including the procedure code(s) and diagnosis code(s). Please also refer to the Help Sheet for additional information.
2. To request reimbursement, please submit the following to the address listed at the end of this form (any missing information may result in delay or denial of the request):
   a. This completed and signed claim form b. Proof of services rendered c. Proof of payment for the services being requested for reimbursement
3. Reimbursement will be sent to the Member at the address Vibra Health Plan has on record. If you believe your address is different than the address of record, please call Member Services at 1-844-388-8268 (TTY users call 711).
4. Retain a copy of all receipts and documentation for your records.

MEMBER INFORMATION

Member ID#	Date of Birth (MM/DD/YYYY)

Member's Last Name	First Name	Middle Initial

CLAIM INFORMATION

Health Care Provider's Name	Setting where treatment was received	Telephone Number	Tax Id Number or National Provider Identification Number (NPI)

Address of Health Care Provider	Were services received outside of the U.S.? ☐ No, proceed to the next section ☐ Yes, answer the following questions: In what country was the patient seen? In what language was the bill written? In what currency was the bill paid?

Diagnosis Codes (if known)	Diagnosis Description (e.g., flu, broken leg, asthma)	Date(s) of Service	Procedure Codes for each service provided (if known)	Procedure Descriptions (e.g., x-ray, office visit, lab work, leg cast, etc.)	Amount Paid
		/ /			$
		/ /			$
		/ /			$
		/ /			$
		/ /			$
		/ /			$
				Total amount paid	$

Attach another sheet if more services are reported.

Member or Personal Representative signature is required

I attest that the above information is true and accurate and that the services were received and paid for in the amount requested as indicated above. I acknowledge that if any information on this form is misleading or fraudulent my coverage may be cancelled and I may be subject to criminal and/or civil penalties for false health care claims. I also understand that Vibra Health Plan may request any additional information it deems necessary to verify that services were received and payment was made.

Printed name	Signature	Date

Please submit this form and all documentation to:

Vibra Health Plan
Attn: Member Claims
PO Box 60250
Harrisburg, PA 17106-0250

Vibra Health Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

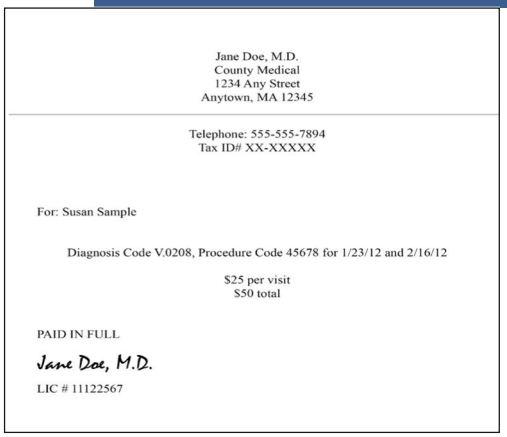
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-844-388-8268 (TTY: 711).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 **1-844-388-8268**（**TTY**：**711**）。

MEMBER REIMBURSEMENT CLAIM FORM HELP SHEET

FIELD NAME	DESCRIPTION
Member's ID#	Vibra Health Plan ID#, found on the front of the Vibra Health Plan ID card.
Member's Name	Last and First names and Middle Initial of member who received services.
Member's Date of Birth	Date of birth: MM/DD/YYYY
Provider's Name, Address, Telephone Number, Tax ID number or National Provider Identification (NPI) number	A provider includes, but is not limited to, hospitals, physicians, optometrists, psychiatrists, licensed clinical social workers, Durable Medical Equipment suppliers, and pharmacies (for covered items that are not submitted to your pharmacy vendor).
In what setting did the patient receive treatment?	Such as office, emergency room, outpatient hospital (for X-rays, tests), inpatient hospital, clinic, medical supply store.
If services were rendered outside of the U.S.	If applicable, indicate in what country services were provided, in what language (if not English) the bill and proof of payment were written, and in what currency the bill was paid.
Diagnosis: What was the patient seen for?	Provide a diagnosis code (if known) and detailed description of illness or injury. (e.g., flu, broken leg, manic-depressive disorder, asthma).
Date(s) of Service	The date(s) the services were provided to the patient.
Procedures, Services, or Supplies Provided	Provide a procedure code (if known) and detailed description. (e.g., x-ray, office visit, lab work, leg cast, etc.).
Total Amount Paid	Total amount for which you are requesting reimbursement.
Proof of Service(s)	A document that demonstrates the service was actually rendered, listing date(s) of service, service(s) provided, and dollar amounts paid.
Proof of Payment	A document that demonstrates payment made by the member was received by the provider of service. Examples include: The front and back of the cancelled check written to the provider or the bank encoded front of the check written to the provider; a credit card statement or receipt; a statement from the provider, on the provider's letterhead with authorized signature, indicating payment was made; a receipt for purchased items, with the provider's name and address preprinted on the receipt, with items listed and amount paid.

PROOF OF SERVICE AND PROOF OF PAYMENT EXAMPLES


Jane Doe, M.D.
County Medical
1234 Any Street
Anytown, MA 12345

Telephone: 555-555-7894
Tax ID# XX-XXXXX

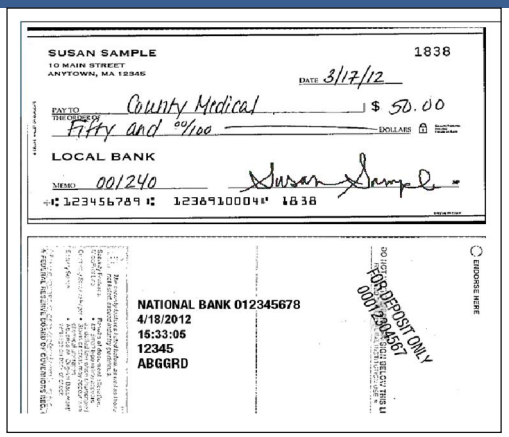
For: Susan Sample

Diagnosis Code V.0208, Procedure Code 45678 for 1/23/12 and 2/16/12

$25 per visit
$50 total

PAID IN FULL
Jane Doe, M.D.
LIC # 11122567

This example demonstrates both proof of payment and proof of service



This example demonstrates proof of payment