HealthPlan OF SAN MATEO DIRECT MEMBER REIMBURSEMENT FORM (DMR)

If you paid for services that are covered by your HPSM health care plan, you can ask HPSM to pay you back. Submit this form with a statement from your provider showing services and cost and proof of payment of that same cost. Cash register and credit card receipts alone are not acceptable as proof of purchase. Reimbursement is not guaranteed. Covered costs will be repaid at whichever amount is lower: the original payment or the maximum plan allowance (minus any cost sharing that may apply).

Member Information (one form per patient per service)

First Name _____ Last Name _____ Middle Initial _____

HPSM Member ID _____ Medi-Cal ☐ HealthWorx (HMO) ☐ CareAdvantage ☐ ACE ☐ Date of Birth (MM/DD/YYYY) _____ Telephone # _____

Mailing Address _____ City _____ State _____ Zip _____

Provider's Name _____ Provider's Telephone # _____

Reason For Request (check all that apply)

☐ Medical ☐ Out of Area emergency ☐ Did not have my ID card

☐ Dental ☐ Out of Network Provider ☐ Other: _____

If HPSM is not your primary insurance and your primary insurance already paid for the service, complete this section

Type of primary insurance that paid for the service. ☐ Dental ☐ Medical

Primary Insurance Company Name _____

Primary Member/Subscriber's Name (Last Name, First Name, MI) _____ Primary Member/Subscriber's ID # _____

I certify that the patient listed on this form is an HPSM member and that the service(s) provided were for the named patient. I also certify that the claim(s) being submitted for payment are not eligible for payment under a no-fault automobile or workers compensation insurance program. I also authorize release of all information pertaining to this claim(s) to the plan administrator, underwriter, sponsored policy holder and/or employer.

Member's Signature (Claim(s) without the member's signature will be rejected.) _____ Date _____

Special Instructions:

Items submitted with this form must have the following information clearly legible or reimbursement could be delayed or denied.

- ☑ Provider name and address
- ☑ Services provided with all associated costs and copy of primary carrier remittance advice
- ☑ Itemized bill of all services provided with associated costs with proof of payment (receipt from provider, credit/debit card statement)

This form and accompanying materials can be submitted either by email (with scanned documents) or mail (with paper documents)

CareAdvantage members

Email: CareAdvantageSupport@hpsm.org

Mail: Health Plan of San Mateo
c/o The CareAdvantage Unit
801 Gateway Boulevard, Suite 100
South San Francisco, CA 94080

or

Medi-Cal, HealthWorx & ACE members

Email: MemberServicesSupport@hpsm.org

Mail: Health Plan of San Mateo
c/o Customer Support
801 Gateway Boulevard, Suite 100
South San Francisco, CA 94080

Reimbursement and correspondence will be issued to the primary member. Claims are subject to limitations, exclusions and other provisions.