Reimbursement Request Form

Completion Guide

This form is for the reimbursement of any eligible out-of-pocket expenses. Please be advised that missing information may result in the denial or delay of your request. Please do not highlight anything on this form or any supporting documentation, as highlighted sections become unreadable in our imaging software.

Step 1: Member Information

- Complete required fields with member information and follow the steps below.

Step 2: Reimbursement Information

- **Did You File Online**: If a claim was filed online at www.memberportal.myzinghealth.com, mark "Y" for yes;if not, mark "N" for no.
- **Date(s) Expense(s) Incurred / Date(s) of Purchase**: Provide the date or range of dates the expenses were incurred or purchase(s) were made.
- **Merchant/Provider Name**: Provide the name of the merchant or facility where the expense was incurred or purchase was made.
- **Product Purchased**: Provide a description of the product purchased, if applicable.
- **Claim Amount**: Provide the total amount requested for the specified expense.
- **Total Reimbursement Requested**: Total the amounts in the "Claim Amount" boxes.

Step 3: Member Certification

- Sign and date the form after reading the Member Certification.

Eligible expenses are determined based on the terms and conditions of the Medicare Advantage plan, review the plan's certificate of coverage for a description of plan benefits, exclusions, limitations and conditions of coverage.

Documentation Requirements

Documentation for expenses includes a third-party receipt containing the following information:

- Date service was received or purchase made
- Description of service or item purchased
- Dollar amount (after insurance, if applicable)

Unacceptable forms of documentation include the following:

- Provider statements that only indicate the amount paid, balance forward or previous balance
- Credit card receipts that only reflect a payment
- Copies of checks
- Bills for prepaid medical expenses where services have not yet occurred
- Handwritten receipts

When submitting a receipt for a co-payment amount, please be sure the co-payment description is on the receipt. In some cases, you will need to ask for a receipt at the point of service. If "co-payment" is not clearly identified, have the provider write "co-payment" on the receipt and sign it.

Instructions:

1. Complete all sections of this form.
2. Securely email, mail or fax completed form and **documentation** to:
   Secure Email: Zinghealth@healthacountservices.com
   Address: P.O. Box 2306 Fargo, ND 58108
   Fax: (833) 546-0390
3. If you have any questions about completing this form, please contact Zing Health Member Services at (866) 946-4458. We have representatives available Monday-Friday, 7:00 am to 8:00 pm CST.

Reimbursement Request Form

Step 1: Member Information
*Required Fields

*Member Name (First, MI, Last)

*Member ID

*Birth Date (MM/DD/YYYY)

*Phone Number

*Permanent Address

Email Address

*City

*State

*Zip Code

Step 2: Reimbursement Information

Claim Information

***Did You File Online (Y or N)**	***Date(s) Expense(s) Incurred / Purchase Made**	***Merchant/Provider Name**	***Product Purchased**	***Claim Amount**
				$
				$
				$
			***Total reimbursement requested**	=

Step 3: Member Certification

I certify that the reimbursement request I am submitting contains eligible out-of-pocket expenses as defined by the Zing Health Medicare Advantage Plan. I have not been previously reimbursed for these expense(s), nor am I seeking reimbursement for these expenses from any other source. In filing this claim I understand that I should retain copies of original receipts. False receipts and alterations to original receipts may result in civil or criminal prosecution. Submitting a claim does not guarantee reimbursement. I authorize a deduction in my account in the amount of the reimbursement. I understand that requests related to eligible expenses are only eligible for cash reimbursement if the item(s) could not be purchased with the Zing Health due to circumstances beyond my control and by submitting this request, I certify that to be the case with this reimbursement request. I understand that Zing Health, its agents or employees, will not be held liable if I submit ineligible expenses for reimbursement. By submitting this request, I certify that the information provided is complete and accurate. If there are any changes in the provided information, I understand it is my responsibility to notify Zing Health. I acknowledge that this form may be electronically signed and I agree that the electronic signature(s) appearing on this document are the same as handwritten signatures for the purpose of validity, enforceability, and admissibility.

*Member Signature

*Date