ATRIO Health Plans Direct Member Reimbursement
(Medical Claims, Gym Fees and Flex Card)

Thank you for choosing ATRIO Health Plans for your health insurance coverage. Use this form for any reimbursement requests you may have. **For medical claims:** If you received services from a contracted medical provider, your claim should be submitted by the provider. You do not need to submit this form unless you know that your claim was not submitted. Please complete a separate form for each member or provider. **For Gym or Flex Card reimbursements**: If you were denied access to an approved fitness center or paid out-of-pocket due to an error with your flex card, please complete this form to request a reimbursement. Approved reimbursement amounts will be deducted from your Flex Card allowance up to the maximum amount.

Instructions

1. Complete the form on the following page.
2. Attach original proof of payment or provider bill to page 3 of this form. Cash register receipts will not be accepted. Please retain copies of proof of payment for your records, as the original will not be returned.
3. Sign the completed form where indicated
4. Submit the completed form(s) and proof of payment in one of the following ways:

Mail ATRIO Health Plans Attn: Reimbursements 338 Jericho Turnpike, #135 Syosset, NY 11791		**Fax** 1-866-298-8412 **Email** CustomerService@atriohp.com	
Deliver To ATRIO Health Plans 2270 NW Aviation Drive Suite 3 Roseburg, OR 97470	ATRIO Health Plans 810 O'Hare Parkway Suite B Medford, OR 97504	ATRIO Health Plans 404 Main Street, Suite 5 Klamath Falls, OR 97603	ATRIO Health Plans 2965 Ryan Drive SE Salem, OR 97301
		ATRIO Health Plans Baton Rouge, LA 70809	ATRIO Health Plans Murfreesboro, TN 37129

Be sure to include appropriate documentation of proof of payment. Incomplete forms submitted without the necessary information and documentation may result in a delay in your reimbursement or may be returned for additional information. Reimbursement form must be received no later than one year after the date you paid for the service.

If you have questions, please call Customer Service at **1-877-672-8620** (TTY 711), daily from 8 a.m. to 8 p.m. local time.

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What services are you requesting reimbursement for:

☐ Medical Claim ☐ Dental ☐ Fitness ☐ Over-the-Counter (OTC)

Complete the following information below:

Member Information

Member Name:		Gender: ☐ Male ☐ Female
Member ID #:		DOB:
Phone #:		
Address:		
City:	State:	Zip:

Payment Information

Name of facility or provider you paid out-of-pocket to:
Total Reimbursement Amount Requested (what did you pay out-of-pocket):
Month(s) Reimbursement Requested For (what month(s) did you pay out-of-pocket in):
Please indicate why you paid out of pocket for this service: **(Continue to next page)**

I certify that the above statements are correct and hereby authorize any physician, hospital, or provider/facility to supply ATRIO Health plans any information required in connection with this reimbursement claim. A photocopy of this authorization shall be as valid as the original.

Member Name (Print Name): _____

Member Signature: _____ Date: _____

Medical Claim, Gym fees, or Flex Card payment information (amount charged)
MUST include the following information

Medical Claim Bill Must Include	Flex Card Payment Information Must Include:
Provider's name and address (include the name of the provider who is attached to this claim and his/her address where you received care)	**Provider/Facility's name and address** (include the name of the provider/facility)
Diagnosis code (a code that describes the medical condition, which must be on claims submitted by health care professionals. Multiple diagnosis codes may be listed. You can typically find this on your billing statement.)	**Service Provided** (Dental, Gym, OTC)
Procedure code (a 5-digit alpha/numeric code that identifies the medical service/procedure provided during the time of service. You can typically find this on your billing statement.)	**Date of service** (the date you received the service)
Date of service (the date on which the medical service was provided)	**Itemized charges** (a list of billed charge amounts from the provider/facility and what you paid for each)
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Contact the medical provider or facility if you need additional information. Reimbursement claims will be processed and reimbursed within 30 days.

Rules and Exclusions

For a fitness facility to be considered for reimbursement under this benefit, the following criteria must be met:

- The fitness facility is open to the public
- The fitness facility exists primarily to provide equipment and resources to members for the purpose of maintaining or increasing physical activity and fitness in an individualized/self-directed manner.
- The facility cannot mandate fitness classes, training, or lessons as a requirement for membership and must provide general safety for its membership.

The Fitness Benefit does not include reimbursement for:

- Initiation fees, per-use fees, or other program fees for items such as classes, lessons, boot camps, contests, diet/meal plans or coaching fees.
- Fitness or activity aids such as computer software, smart phone applications, pedometers, paper based or electronic planners, progress/tracking tools, gaming console fitness/activity software and hardware, clothes, or gear.
- Perishables such as food, drinks, or fitness supplements.
- In-home activity and equipment such as treadmills, weights, magazine subscriptions, workout/training videos.
- Social or recreational communities and activities such as golf, tennis, fencing, dancing, nature appreciation walks, spa services, etc.
- Other administrative billable items such as locker fees, towel fees, maintenance fees, child-care fees, application processing fees, past due payment fees, guest fees or trial use fees.

Include your proof of payment with this form
(Be sure to keep a copy for your records)

Attach Proof of Payment Here