DetegoHealth
Discover A Better Plan

Reimbursement Form Instruction Guide

What is this form for?
This form is for members who need reimbursement for an expense that was paid out-of-pocket.

To ensure faster processing...
If you write on the form, please use black or blue ink and print clearly and legibly. You can also use your computer to complete this form and then print it out and mail or fax to us. Complete all the applicable fields on the form. Ask your provider for the Provider Information, or have them fill it out for you.
Be sure to submit a separate form for each reimbursement request (each date of service requires a completed form).

If you have other insurance or Medicare and it is primary to your Detego Health Benefit plan, please include the explanation of benefits (EOB) from your insurance or Medicare.

Ask your provider to give you a Superbill or Invoice that includes all of the following for each date of service.

Important: This information must be on the invoice as it is required to process the reimbursement.
Missing information can result in a delay or non-payment of the reimbursement.
PLEASE BE SURE THE INFORMATION IS CLEAR AND READABLE.

- **Patient Name**
- **Diagnosis Codes** *(Request with date of service after October 1, 2016 must be ICD10)*
- **Procedure Codes** *(CPT, HCPC) - with any applicable modifiers*
- **Units for each procedure code**
- **The billed amount for each procedure code**
- **Place of service code**

What happens next...
After we process your form, we will send you an Explanation of Benefits (EOB). The EOB will explain how the charges were processed and any amount you may owe your health care provider. ***Please keep your EOB on file for future reference.***

Be sure to attach the Superbill/Invoice and any receipts of your payments.

This completed form, together with the itemized bills, should be submitted to:

DETEGO HEALTH
759 N 114TH ST. STE 300
OMAHA NE 68154

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REIMBURSEMENT FORM

MEMBER IDENTIFICATION NUMBER ____________________

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NAME (LAST, FIRST, MIDDLE INITIAL):

MAILING ADDRESS:

CITY, STATE AND ZIP CODE:

PHONE NUMBER:

EMPLOYED?
YES ☐ NO ☐ RETIRED ☐

DATE OF RETIREMENT:

2

GROUP NUMBER: (THIS IS FOUND ON YOUR BENEFITS CARD)

IDENTIFICATION NUMBER

PATIENT'S FULL NAME: (LAST, FIRST, MIDDLE INITIAL)

PATIENT SEX: ☐ **MALE** ☐ **FEMALE**

PATIENT'S DATE OF BIRTH:

PATIENT'S RELATIONSHIP TO INSURED
SELF ☐ SPOUSE ☐ CHILD ☐ OTHER ☐

EXPLAIN OTHER:

3

PROVIDER NAME:

NPI NUMBER:

PROVIDER ADDRESS:

CITY, STATE AND ZIP CODE:

PROVIDER TAX IDENTIFICATION NUMBER:

GROUP/FACILITY NAME:

PHONE NUMBER:

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TYPE OF TREATMENT RECEIVED:
Check only one type and attach itemized statements.
Please use a separate claim form for each different type of treatment.

PLEASE NOTE:
Preventive care includes immunizations, annual well baby care.

☐ **INJURY:** Date of Accident
☐ **ILLNESS:** Date of First Symptom
☐ **PREGNANCY:** Date of Conception
☐ **PREVENTIVE:** Date of Service
☐ **VISION:** Date of Service
☐ **DENTAL:** Date of Service

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SERVICES RENDERED

PROFESSIONAL:
--ALL FIVE DIGIT CPT/HCPCS CODES & AMOUNT BILLED FOR EACH
--ALL ICD-10 DIAGNOSIS CODES

HOSPITAL/MEDICAL CENTER:
--ALL ICD-10 DIAGNOSIS CODES
--EACH REVENUE CODE & AMOUNT BILLED FOR EACH
--ALL DIAGNOSIS RELATED GROUPS (DRG) CODES

IF ANY OF THE REQUESTED INFORMATION IS OMITTED/NOT PROVIDED, YOUR REQUEST FOR REIMBURSEMENT MAY BE DENIED.

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WAS ILLNESS OR INJURY WORK RELATED:
☐ **YES** ☐ **NO**

NAME OF EMPLOYER:

ADDRESS OF EMPLOYER:

IF INJURY, WAS A MOTOR VEHICLE INVOLVED?:
☐ **YES** ☐ **NO**

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IS PATIENT COVERED UNDER ANY OTHER HEALTH BENEFITS PLAN (BESIDES MEDICAID, MEDICARE OR CHAMPUS)?
☐ **YES** ☐ **NO**

INSURANCE CO: ____________________

ADDRESS: ____________________

EMPLOYER: ____________________

NAME: ____________________

POLICY #: ____________________

EFFECTIVE DATE OF COVERAGE: ____________________

SEX OF INSURED: ☐ **MALE** ☐ **FEMALE**

DATE OF BIRTH: ____________________

RELATIONSHIP TO PATIENT: ____________________

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ASSIGNMENT OF BENEFITS:

☐ **Check this box if you would like Detego to pay expenses directly to the doctor/provider.**

By signing below, I am stating that the information above is correct. Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information, may be guilty of a criminal act punishable under law and may be subject to civil penalties.

SIGNATURE: ____________________

DATE: ____________________

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SECTION INSTRUCTIONS FOR FORM

#	Section	Instructions
1	**Name,address,and employment status**	Please show the name exactly as it appears on your Detego Health Benefits identification card and specify the current address including zip code. Check appropriate box indicating the employment status. If retired, give date of retirement.
2	**Patient Information**	Make sure the group number is exactly as it appears on the ***Detego Health Benefits Identification card.*** List patient's full name, no nicknames or initials. Check the appropriate blocks for the patient's sex and relationship to the insured. Ensure the patient's correct date of birth is shown.
3	**Provider Information**	List the provider's name, address, and phone number as well as any group or facility name that they are a part of. List the Provider's Tax Identification Number and their NPI (National Provider Identifier) Number. Please ask your provider to fill out this section or give you these numbers if they are not listed on your invoice.
4	**Type of Treatment Received**	Check only one treatment type (injury, illness, pregnancy, or preventive care) and specify date of injury, date of first symptom, date of conception or date preventive care was received. You may attach multiple itemized statements if they are for one type of treatment.
5	**Diagnosis or Symptoms of Illness or Injury**	Give diagnosis or a brief description of symptoms. If preventive care services were received, state the type of care (routine physical, hearing exam, vision exam, immunization or diagnosis, etc).
6	**If Illness or Injury is Work Related or a Motor Vehicle is Involved**	Check appropriate box and enter name and address of employer. Check appropriate box if a motor vehicle was involved.
7	**Other Insurance**	Please check appropriate box. If "YES", complete the required information.
8	**Signature and Date**	Please sign and date this form and attach your physician's itemized invoice.