REIMBURSEMENT FORM ☐ MEDICAL ☐ DENTAL

To complete this form, please read the instructions.

SECTION A - INSURED PERSON/PATIENT INFORMATION			
Contract Number	Insured Person/Patient Name	Initial	Insured Person/Patient Last Name
Postal address (Urb., Street Number, PO Box, City, State, Zip Code)			
Group Number	Group Name		Birth date ___ / ___ / ____ month day year
Home phone number	Fax number		Alternate phone number

SECTION B - OTHER PLAN INFORMATION/COORDINATION OF BENEFITS	SECTION C - INFORMATION OF ACCIDENT OR INJURY (if applicable)
Does the insured person have another health plan? [ ] Yes [ ] No	The condition or injury is related to:
Name of health plan / Effective date	[ ] Work accident
Policy/contract number	[ ] Car accident
What type of coverage do you have with the other plan? [ ] Individual [ ] Couple [ ] Family	[ ] Another accident, explain
What benefits coverage do you have with the other plan? [ ] Medical [ ] Dental [ ] Pharmacy [ ] Vision	Date of accident ___ / ___ / ___ (month/ day /year)
Plan telephone number	How did the accident occur?
Do you have Medicare? [ ] Yes [ ] No [ ] Part A [ ] Part B [ ] Part D	
Medicare Beneficiary Identifier (MBI)	

SECTION D - PROVIDER AND MEDICAL SERVICES INFORMATION

Provider Name (who provided the services)	Speciality:	National Provider Identifier (NPI):	State License Number:

Date of Service	Place of Service	Service Description	Procedure Code	Service Charges	Total Paid by Patient

Diagnostic(s) Code(s)

A.	B.	C.	D.	E.	F.	G.
H.	I.	J.	K.	L.	M.	N.

SECTION E - INSURED PERSON/PATIENT AUTHORIZATION

I certify that the information provided on this procedure form is correct and complete. I authorize any physician, hospital or other medical facility to provide information requiered for MCS analysis of this request for reimbursement.

_____ Signature of insured person or authorized representative

_____ Date

INSTRUCTIONS

I. PLEASE READ THIS IMPORTANT INFORMATION

1. Use this form to request reimbursement of medical and dental expenses covered and incurred by non-participating providers when applicable.

2. **If you claim expenses for more than one family member, please use a reimbursement application for each member.** If you claim expenses for more than one provider (medical, hospital, laboratory), you must attach the official receipt for each vendor who served.

3. Complete the boxes on the procedure form for reimbursement. Include detailed receipts in original for all services supplied or claimed.

4. Receipts for reimbursement **have to** be legible and **have to** include the following information:

   A. Original official receipt- The original receipt **has to** include the logo or seal of the service provider. That receipt **has to** contain the provider's name, address, phone number and specialty.

   B. National Provider Identifier (NPI)

   C. State license

   D. Complete name of the person who received the service

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E. Date of service (month / day / year)
F. Description of the service received. If the receipt is for more than one service, each service has to be detailed. Laboratory receipts must specify all lab tests conducted to the patient.
G. Indicate the service code and description of diagnosis (number that identifies the diagnostic - ICD-10).
H. Indicate the charge for each service and the paid cost of each detailed service.
I. The receipt must indicate the tooth or the piece worked **(only applies to Dental).**
J. Include side of piece worked. Each surface has separate fee **(only applies to Dental).**
K. Include the Diagnostic(s) Code(s) (medical condition for which you were treated)

Note: Individual cash receipts, canceled checks, receipts for money orders, personal breakdowns and invoices indicating only "Balance Due" **are not acceptable.**

Forms that do not contain the requested information may delay the processing of your refund or be returned to you.

You can send the form by mail to: MCS, PO BOX 9023547 San Juan PR 00902-3547. You can also deliver in person at: **MCS Plaza, Suite 105.**

If you have any questions regarding how to complete this form or any related questions please contact our Customer Service Department at 787-281-2800 (Metro Area) or at 1-888-758-1616 (Toll free) Monday to Friday from 8:00am to 8:00pm and Saturdays from 8:00am to 4:30pm.

It is important for you to know that out-of-network inadvertent and involuntary charges are not subject to payment or billing beyond the economic responsibility incurred under the terms of the in-network service contract. Any attempt from the provider to charge or bill must be informed immediately to our Customer Service Department at the aforementioned phone numbers and hours. Involuntary out-of-network services means health or medical services that are covered by the plan, when provided by an out-of-network provider, and when the insured person uses an in-network facility to receive covered services, but the in-network services are not available at that facility at that moment.

II. CONFIDENTIALITY NOTE

This formulary, once completed, contains privileged and confidential information for exclusive use of the person or entity it addresses. If you receive it by mistake, you are not authorized to review, disclose, spread, distribute or photocopy it. If you received this information by mistake please notify immediately at 787-758-2500 to make arrangements to return or destroy the documents.

III. FRAUD ADVICE

In agreement with the dispositions of Act 230 of August 9th, 2008, we warn you that Article 27.250 of the Code of Insurances of Puerto Rico arranges for the following: "Any person who knowingly and with the intention to defraud present false information in an insurance request or, present, help or make present a fraudulent complaint for the payment of a loss or benefit, or present more than one claim for the same damage or loss, will incur in serious crime and if convicted, sanctioned by each violation with a fine no smaller than five thousands ($5,000) dollars, nor greater of ten thousand ($10,000) dollars or imprisonment by a fixed term of three (3) years, or both rulings. If aggravating circumstances mediate, the fines established could be increased up to a maximum of five (5) years; if extenuating circumstances mediate, it could be reduced a minimum of two (2) years.

IV. COORDINATION OF BENEFITS INFORMATION

If you or any of your dependents are covered by another health insurance, please provide the information requested in Section B OTHER PLAN INFORMATION (COORDINATION OF BENEFITS).

If you submit for reimbursement charges for services or supplies that have been partially paid or denied by other health insurance, including Medicare, you must include the Explanation of Benefits of the other insurance or Medicare and a copy of the denial letter, with detailed invoices of the services or supplies.

V. USES AND DISCLOSURE AUTHORIZED BY LAW OF THE PROTECTED HEALTH INFORMATION

MCS Life Insurance Company has the obligation and commitment of keeping the privacy and confidentiality of your protected health information (PHI) according to the Health Insurance Portability and Accountability Act of 1996 (HIPAA). MCS Life Insurance Company as Plan administrator can disclose PHI without the insured's authorization to fulfill functions related to your treatment, payment of medical services and health care operations.