XO Health

Reimbursement Instructions

How to Complete This Direct Member Reimbursement (DMR) Form

When to use this form:

- Fill out this form if you're asking for medical reimbursement and you paid a doctor, healthcare professional, or service provider who did not bill us directly.
- **Do not use this form for prescription drug claim reimbursements.** Visit xohealth.com or call the member service number on your member ID card to get a *Prescription Drug Claim* form.

How to fill out this form:

1. **Complete each section.** Print clearly in black ink only. If you need another form, you can download the PDF at xohealth.com and print it.
2. **Submit itemized receipts** with this form.
3. **Sign and date the bottom of the completed form.** Appointed representatives must have an *Appointment of Representative* form on file, or you can submit one with this form. You can find an *Appointment of Representative* form at xohealth.com.

Where to send this form:

Medical Service Reimbursement

Mail:
XO Health Member Services
565 Willowbrook Center Pkwy.
Willowbrook, IL 60527

Email:
claim.appeals@xohealth.com

Things to remember:

Please submit the form within 365 days from the date you received the service or item. If the form is incomplete, processing delays may occur while we find the needed information. If we approve your request, it can take up to 30 days to send payment once we have all the required information.

Acknowledgment

I understand it is a crime to fill out this form with information I know is false. I understand the submission of a claim is not a guarantee of payment, or payment in the full amount. I understand if the services are deemed covered services then the health plan will reimburse me up to the benefit amount minus any applicable deductibles, coinsurance, or copays. I understand XO Health may need to disclose the information on the form to other persons and entities to process the claim.

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Reimbursement Form

Member Information (Print Clearly)

Member's Full Name		
XO Health Member ID Number	**Birth Date** (MM/DD/YYYY)	**Phone Number**
Address		
City	**State**	**ZIP Code**
Email Address		

Doctor, Healthcare Professional, or Supplier Information

Provider's Name	Phone Number
Address	
City	**State**	**ZIP Code**

Claim Request (Information must match your itemized bill)

Date of Service or Procedure (MM/DD/YYYY)	Amount Paid
Description of Procedure(s), Service(s), or Item(s)	

By signing and submitting this form, I certify that the information is true and correct

Member or Authorized Representative Signature	Date (MM/DD/YYYY)

Questions? We're here to help! Just call us at (833) 817-8877, Monday through Friday from 8am to 5pm EST.