AmeriHealth NEW JERSEY

Remember:
To avoid delays be sure member ID is provided

Out of Pocket Maximum Reimbursement Form

Section A Subscriber Information

Subscriber's Name (First, Middle, Last)		Subscriber's Member ID#
Home Address		
City	State	Zip Code
Home Telephone #	Business Telephone #	

Section B Out of Pocket Expenses for Reimbursement Consideration

Note: You must attach all associated paid receipts for reimbursement consideration. If you require additional space, you may attach a separate sheet. Please make sure additional sheets contain your member ID information.

Date of Service	Patient Name	Provider	Copayment Amount Paid
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
13.			
14.			
15.			
16.			
17.			
18.			
19.			
20.			
21.			
22.			
23.			
24.			
Total			

Please see reverse side for instructions and mailing address.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIAL FALSE INFORMATION OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME AN SUBJECTS SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

SIGNED - EMPLOYEE OR SPOUSE	DATE
X	

Instructions

Section A:
Please fill out all information to identify the subscriber and the policy.
Section B:
Please fill out this section with all pertinent information for all expenses for the reimbursement information.
Note…This Reimbursement is for co pays associated with Medical Services Only. Co pays associated with Dental, Routine Vision and Out-Patient Prescriptions are not eligible for this reimbursement.

- Date of Service is the date of the office visit or date the services were provided by the physician or facility.
- Patient Name is the name of the person on the policy for which the services were rendered.
- Provider is the name of the physician or facility that rendered the medical services.
- Amount Paid is the amount that was paid in the form of medical co pays to the physician or facility.

Accepted Forms of Proof of Payment:

- Receipt from the physician or facility
- Paid invoice from the physician or facility
- Canceled check written to physician or provider

Please send originals and keep a copy for your records

Once form has been completed, please enclose form with proof of payment to the address listed below or faxed to the attention of OOP Reimbursement at 215-238-7066. If you have any questions, call **AmeriHealth Member Services at 1-800-877-9829.**

Please mail all associated receipts for co-payments to:
AmeriHealth Member Services
P.O. Box 42952
Attention: OOP Reimbursement
V/2 2nd Floor
Philadelphia, PA 19101

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