Dear Medicare Advantage Member,

Thank you for reaching out to a representative of Peak Health about your recent international claim. Please note that Peak Health will consider international claims for coverage only in the case of an emergency.

Additionally, to ensure that your claim is properly reviewed we would ask that you provide the following information outlined in the accompanying international claims form and any supporting documentation.

- Date of the incident or injury
- Location of the incident or injury, provide address of provider if available.
- Reason for treatment – describe the illness, injury, or symptoms requiring treatment.
- If this was an emergency, were you treated at an urgent care facility or hospital?
- If the incident was not an emergency, were you treated at a clinic or doctor's office?
- Description of services provided
- List of all charges for services rendered
- Proof of payment in U.S. dollars including all pertinent banking details such as copy of check and or transfer of electronic funds.

If the claim is not written in English, supply a copy of the complete claim form, and any supporting documentation that was provided. Once Peak Health receives these documents, we will take some time to review and consider for coverage. If you should have any questions, feel free to call Peak Health Medicare Advantage Member Service at 1.855.9MA.PEAK (1.855.962.7325) / TTY 711 Monday through Friday 8:00 am to 8:00 pm ET.

Sincerely,

Team Peak

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Member Reimbursement Form for Medical Claims

ONE FORM PER PATIENT PER PROVIDER
Please print clearly, complete all applicable sections and sign.

1. Member's Name: (Last) (First) (Middle)	2. Member ID#:	3. Group ID#:
4. Member's Address:	5. Phone Number	6. Date of Birth:

The following information must be obtained from your provider or included on your itemized statement or bill from your provider. If the itemized statement includes the information required in fields 7-8, you do not need to complete those sections on the form. Do not send originals as they will not be returned to you.

7. Dates of Service	Place of Service (Office, ER, Urgent care, Hospital, Clinic, Pharmacy, Ambulance, Home)	Diagnosis Codes (ICD-10)	Procedure Codes	Amount Charged	Amount Paid

8. Provider's Name:

_____

Provider's Tax ID#: Provider's Billing Address:

_____

_____

Provider's NPI *(not required):*

_____

9. Other Insurance information: Is the member covered by another plan?

Yes No

Name of other insurance company:

_____

If the other insurance made a payment, please include Explanation of Benefits

10. Foreign Claims

For services out of the country, please explain where services were rendered (Office, ER, Urgent care, Hospital, Clinic, Pharmacy) and explain nature of injury or illness:

11. Signature (required):

I attest that the information above is true and accurate, and the services were received and paid for in the amount requested as indicated above.

Signature:_____Date: _____

*****Please provide a copy of your receipt, a provider invoice or a statement that indicates the amount paid to the provider and method of payment, then mail this completed form along with your copy of payment to:**

Peak Health Medicare Advantage, Peak Health, 1085 Van Voorhis Rd, Suite 300, Morgantown, WV 26505

Claims must be received by Peak Heath within 365 days of the date of service. Claims not received within this time frame are ineligible for benefit payment. Submission of this form does not guarantee reimbursement. For any questions, please contact Member Service at 1-855-9MA-PEAK (1-855-962-7325). TTY users should call 711. Hours from October 1 to March 31: 8:00 am to 8:00 pm, 7 days a week. Hours from April 1 to September 30: 8 a.m. to 8 p.m., Monday through Friday. Messages received on holidays and outside of our business hours will be returned within one business day