Enrollee Refund Forms

(For refunds for medical claims)

HYGEIA HMO

Last Name: _____

First Name: _____

Middle Name: _____

Date of Birth: _____

Name of Company: _____ **Hygeia HMO Identification Number:** _____

Home Address: _____

City: _____ **State:** _____

Enrollee's Registration Date (DD/MM/YY): _____

Date of Encounter (DD/MM/YY): _____

Name of Provider: _____

Description of illness or injury: _____

_____

_____

Reason for Refund (Select one)

☐ **Visited out of network provider in an emergency** ☐ **Selected provider requested payment for covered services**

☐ **Others** _____

Please include the following supporting documents order to process the claims

☐ **Medical Reports** ☐ **Original receipt of payment**

☐ **Others, please list** _____

Phone No.: _____ **Email Address:** _____

Total Amount Claimed: _____ **A/C Number:** _____

Account Name: _____ **Bank Name:** _____

Enrollee Agreement:

I certify that all of the above information is accurate to the best of my knowledge; I agree to reimburse the Hygeia HMO if a claim refund made to me is later found to be more than I was entitled to receive or that I am not entitled to a refund. (If this claim form is signed by enrollee's parent or legal guardian, these statements are agreed to by the signer on behalf of the enrollee).

_____ _____

Enrollee's or Legal Guardian's Signature **Date**

For official use only (to be completed by Hygeia HMO official)

Did the enrollee/client contact Hygeia HMO within 24 hours of seeking care outside the network?

Confirmed by Manager/Care coordinator name: _____ Signature: _____

Refund approved? **Yes** ☐ **No** ☐ Reason: _____

Refund Amount Approved _____

Reason for variation between amount claimed and amount approved: _____

_____

Please note that all requests received after 90 days from the date of encounter will not be considered. Refunds will be done according to Hygeia HMO rates for service. This may be lower than what you paid out of pocket.