ANTIDOTE

Antidote Health Plan of Arizona, Inc.
Antidote Health Plan of Ohio, Inc.

Direct Member Reimbursement Form - Medical

Complete and submit a separate form for each member and provider. All sections must be completed for the form to be processed.

Instructions:
To request reimbursement, the following information is required:

☑ **1. Proof of services**
Attach any related claim summaries, an itemized bill, invoice from your provider or Explanation of Benefit forms you may have received for these services, including those received from other insurance companies.

☑ **2. Proof of payment**
Attach any documentation that clearly shows proof of payment, such as credit card statements or receipts, copy of the front and back of the check written to the provider, statement from the provider indicating payment was made, a receipt of purchase items with the provider's name, address and item listed as paid.

For International claims paid in cash over $1,000 U.S. dollars, source of funds proof such as wire transfer, travelers check, credit card statement, etc. is required. For claims inside the U.S. paid in cash over $500 U.S. dollars, source of funds proof such as wire transfer, travelers check, credit card statement, etc. is required.

☑ **3. Sign and date the completed form**

☑ **4. Keep a copy of all bills and claim forms submitted**
Submitted documentation will not be returned.

☑ **5. Mail completed claim form and all attachments to the following address:**

Antidote Health Plan
PO Box 39638
Solon, OH 44139

Any missing or incomplete information may result in a processing delay or a denial. If you have any questions about your benefits or coverage, please check your Evidence of Coverage and your Schedule of Benefits for a complete listing of benefits and requirements for coverage.

☑ **6. If submitting supporting documents at the request of Antidote Health, send the required documents to:**

Attn: Member Submission — Additional Claim Information
Antidote Health Plan
PO Box 39638
Solon, OH 44139

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Is this a new claim?
☐ Yes ☐ No

Are you submitting documentation for a previously submitted claim?
☐ Yes ☐ No

Section 1 – Member who Received Services

Fill out one form per member and provider.

ANTIDOTE ID NUMBER (FROM ID CARD):	FIRST NAME:	MIDDLE INITIAL:	LAST NAME:	DATE OF BIRTH:

ADDRESS:	CITY:	STATE:	ZIP CODE:	COUNTRY:

Section 2 – Other Insurance Information

Please complete the information below if member is covered by another insurance. Attach any Explanation of Benefit or denial letter from other insurance with the submission.

Does member have other insurance?
☐ Yes ☐ No

Other Insurance:
☐ Medicare
☐ Part A ☐ Part B ☐ Part A & B
☐ Medicaid
☐ Motor Vehicle Accident
☐ Worker's Compensation
☐ Travel Insurance (outside US)
☐ Dental
☐ Other Health Insurance
☐ Other: _____

Other Insurance Company Name(s):	Insurance Policy ID Number(s):

Section 3 – Claim Information

This section must be completed, and you will need your health care provider to assist in completing this section. Services performed by multiple providers requires a separate form per provider.

Services received in the U.S.? ☐ Yes ☐ No		**Services received internationally?** ☐ Yes ☐ No		
HOSPITAL/GROUP OR PHYSICIAN NAME:		TIN or NPI # (not required for international submissions):		
PROVIDER ADDRESS (STREET AND NO.):	CITY:	STATE:	ZIP CODE:	COUNTRY:

If services were received outside of the US:
☐ I am an expatriate or retiree living abroad.
☐ I am traveling internationally for pleasure.
☐ I am traveling internationally for business; however, live in the U.S.

Section 3 (continued) – Type of Service

Select most appropriate service that was rendered. Refer to the Evidence of Coverage for benefits and coverage.

Outpatient Services:	**Other Services:**
☐ Physician and other Professional Office Visits (Adult or Pediatric)	☐ Ambulance or air ambulance services
☐ Rehabilitative services (physical, speech, occupational, pulmonary, or cardiac rehabilitation, or language services)	☐ Durable Medical Equipment/Medical Supplies/Prosthetics (including crutches, ostomy supplies and wigs)
☐ Lactation consultation	☐ Emergency Room services
☐ Chiropractic or acupuncture	☐ Observation services (inpatient or outpatient)
☐ Laboratory, radiology, and other diagnostic services (including genetic testing, CT or PET scans, MRI, MRA or nuclear medicine)	☐ Medical drugs (covered inpatient or outpatient drugs)
	☐ Other Service – Please describe:
Inpatient Hospital Admissions:	_____
☐ Acute Hospital, including Emergency Room services	_____
☐ Skilled Nursing Facility	_____
☐ Rehabilitation Facility	

Section 4 – Service Information

Complete all columns in the below grid.

- Enter date(s) of service.
- For services received in the U.S., enter the description of the procedure, services, or code OR attach the itemized bill.
- For international claims, enter description of the procedure, services, or code AND submit the itemized bill.
- Enter the quantity or number of items/visits.
- Enter the diagnosis code or description of the injury/illness.
- Enter the language, country and currency, if not U.S.
- Enter amount provider billed and amount member paid.

Submit one form per member per provider. Multiple services from the same provider can be included on the same form.

Examples – U.S. and International (Intl.) Claims									
Date of Service (Start)	**Date of Service (End)**	**Description of Procedure, Services or Code(s)**	**Qty or # of Items/ Visits**	**Description of Diagnosis or Code(s)**	**Language (if not English)**	**Country (Intl. Only)**	**Currency Billed (Intl. Only)**	**Amount Billed**	**Amount Paid**
0/01/2025	01/03/205	Physical Therapy or 97100	3	Low back pain or M54.5				$123.00	$103.00
02/13/2024	02/13/2024	Office Visit or 99212	1	Headache or R51	German	Germany	Euro	€104.00	€104.00
Enter claim details below:									
Date of Service (Start)	**Date of Service (End)**	**Description of Procedure, Services or Code(s)**	**Qty or # of Items/ Visits**	**Description of Diagnosis or Code(s)**	**Language (if not English)**	**Country (Intl. Only)**	**Currency Billed (Intl. Only)**	**Amount Billed**	**Amount Paid**

Section 5 - Attestation

I hereby authorize any insurance company, organization, employer, hospital, physician, surgeon, or pharmacy to release information requested by Antidote Health Plan and any benefit plan administrator acting on behalf of Antidote Health Plan. I understand that the duration of the authorization is for the term of coverage of the policy or contract under which a claim for health benefits has been submitted. I understand that I have a right to receive a copy of this authorization upon request. A photocopy of this authorization shall be considered as effective and valid as the original.

I attest that the above information is true and accurate and that the services were received and paid for in the amount requested as indicated above. I acknowledge that if any information on this form is misleading or fraudulent, my coverage may be cancelled, and I may be subject to criminal and/or civil penalties for false health care claims. I also understand that Antidote Health Plan may request any additional information it deems necessary to verify that services were received, and payment was made.

MEMBER SIGNATURE (SUBSCRIBER SIGNATURE IF MEMBER IS A MINOR):	DATE:

Checklist

☐ I have completed and signed this form in its entirety.

☐ I have enclosed proof of payment.

☐ I have enclosed proof of service.

☐ I have completed one form per member and provider.