

PLEASE
DO NOT
STAPLE
IN THIS
AREA



**HOSPITAL BASED/PHYSICIAN DIRECTED PROGRAM
REIMBURSEMENT FORM**

1. Participant's first name: _____ Participant's last name: _____	2. Participant date of birth: Month Day Year <input type="text"/> <input type="text"/> <input type="text"/>	4. Member ID #: _____ _____
5. Member's first name: _____ Member's last name: _____	3. Relation to Member: Self Spouse Child Other <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	
		6. Member's Address: _____ _____ _____

NOTE: Reimbursement is based on attendance and payment of program costs.
Reimbursement will not be greater than 50% of amount paid-to-date by member.

Requirements for reimbursement:

- ✓ Prior Authorization is required to be reimbursed for a Hospital Based/Physician Directed Program.
(The Program should contact OSU Managed Healthcare Systems, Inc. 614-292-4700 or 800-678-6269)
- ✓ Copy of Itemized Payment Receipt (only program costs are eligible for reimbursement, not supplements, etc.)
- ✓ Below attendance Record – to be completed at the class by a PROGRAM facilitator

Reimbursement is based on a minimum of 6 sessions attended or at program end if less than 6 remaining.
Reimbursement checks will be made out to the member and mailed to his/her home address.

Program Name: _____

Program Location: _____

Program Facilitator (Name): _____

Program Facilitator (Phone) : _____ - _____ - _____

Duration of Program: _____ Program BEGIN Date: ____/____/____ Prior Authorization #: _____

Date Program Facilitator verifying attendance (please print and sign name) _____

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

OSU Managed Healthcare Systems, Inc. reserves the right to verify attendance and payment of services in the program before reimbursement of benefit.

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

NGS USE ONLY: 278 99404

