Student Health Insurance Program Premium Assistance (SHIP PA) Reimbursement Form

MassHealth is able to pay for out-of-pocket expenses for MassHealth covered services when a SHIP PA student visits a SHIP in-network provider, regardless of whether that provider is also a MassHealth provider. Depending on the provider's policies, the student may be required to pay the out-of-pocket expenses up front before being reimbursed. Reimbursement for such services may be provided for dates of service back to the beginning of the Fall 2016 SHIP plan policy start date. This enhanced benefit will allow for access to even more providers at no extra cost to students.

Instructions:

1. Complete **Part 1: Member Information** & **Part 2: Information about Service Received** and sign below.
2. Attach with this form an Explanation of Benefits (EOB), or other proof of the services received and costs incurred. (Including an EOB may speed up processing)
3. Return completed form in one of the following ways:
   a. **Email** (Please indicate "Reimbursement" in the Subject Line)**:** MassHealthSHIPPA@umassmed.edu
   b. **Mail:** Premium Assistance Program P.O. Box 120068, Boston, MA 02112 [ATTN: SHIP]
   c. **Fax:** 617-886-8400 [Subject Line: SHIP PA]

Part 1: Member Information

1. Name: _____
2. MassHealth Member ID Number: _____
3. Date of Birth: _____
4. Address: _____
5. Phone Number: _____

Part 2: Information about Service Received

1. Date(s) of Service: _____
2. Type(s) of Service Received: _____
3. Provider Name: _____
4. Provider Address: _____
5. Provider Phone Number: _____
6. Member Responsibility ($): _____

Signature:

I certify under pains and penalty of perjury that what is stated on this form is correct and complete to the best of my knowledge.

Member Signature: _____ Date: _____

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Checklist:

- □ Are you currently enrolled in the Student Health Insurance Program Premium Assistance (SHIPPA)?
- □ Was the service received a MassHealth covered service?
- □ Was the provider a SHIP in-network provider but not a MassHealth provider?
- □ Is the SHIPPA Reimbursement Form filled out completely and correctly?
- □ Is there an Explanation of Benefit (EOB) attached with the form?

Definitions:

1.	**Name**	Your name as it appears on your MassHealth ID card
2.	**MassHealth Member ID Number**	12-digit member ID number on your MassHealth ID card
3.	**Date of Birth**	MM/DD/YYYY
4.	**Address**	Complete address to send the reimbursement check
5.	**Phone Number**	Preferred daytime contact number we can use to reach you if we have questions
6.	**Date of Service**	Date that you received the service from the provider
7.	**Type of Service Received**	What service did you receive from the provider (needs to be a MassHealth covered service)
8.	**Provider Name**	Name of the doctor/physician/hospital/clinic
9.	**Provider Address**	Address for the doctor/physician/hospital/clinic
10.	**Provider Phone Number**	Phone number for the doctor/physician/hospital/clinic
11.	**Member Responsibility**	The amount of copay/deductible/coinsurance listed on the EOB as member responsibility or the amount you paid for the service received
12.	**EOB**	Explanation of Benefits - Obtained through your insurance company. Including this with the reimbursement form will help speed up processing time.