MDwise
MEDICARE

# Direct Member Reimbursement Form

**Supplemental Benefits**

Please fill out this form completely. Supplemental benefits will be reimbursed up to the benefit level. You can find your benefit limits in your Evidence of Coverage or by calling Member Services at 833-358-2140 (TTY:711)

**Proof of payment MUST be included with this form for consideration.**

Member name: _____ Member ID: _____

Phone number: _____

Address: _____

(Street) (City) (State) (Zip)

**Supplemental Benefits**

☐ Fitness Benefit Amount Paid: _____ Date Paid: _____

☐ Eyeglasses Amount Paid: _____ Date Paid: _____

☐ Hearing Aids Amount Paid: _____ Date Paid: _____

☐ Worldwide Emergency Amount Paid: _____ Date Paid: _____

Note: Attach all documentation provided by the office showing services, diagnosis and charges.

Signature: _____ Date: _____

Please mail, fax or email completed form along with proof of payment to **(within 12 months of service)**:

MDwise Medicare
Attention: Member Services
PO Box 44092
Indianapolis, IN 46244-0092
Fax #: 855-417-5621
Email: medicarememberservices@mdwise.org