Date

Claimant Name

Claimant Address

City, Zip Code

Re: Request for Reimbursement of Out-of-Pocket Medical Expenses

 Claim #:

Dear (Claimant First, Last Name),

Enclosed you will find the form and detailed information necessary to successfully process your request for reimbursement of out-of-pocket health care expenses associated with your workers’ compensation claim. Please send to my attention the fully completed reimbursement form and supporting documents.

To avoid future out of pocket expenses, you must ensure to select an Injury Management Organization (IMO) network provider. To find an in-network provider please visit the IMO website at: <https://injurymanagement.com/find-a-provider/>

Because your employer subscribes to a healthcare network, you may become responsible for costs resulting from out-of-network services unless that treatment is associated with medical emergencies or is pre-approved by the network.

Within 45 days of your request, you will receive an explanation of benefits showing approval, reduction, or denial of the reimbursement. If you disagree with the determination, you have the right to request medical dispute resolution from the Texas Department of Insurance, Division of Workers’ Compensation. For more information call 800-252-7031 or access this link: <https://www.tdi.texas.gov/wc/employee/index.html>

If you have any questions, do not hesitate to call me.

ADJUSTER SIGNATURE

ADJUSTER NAME

PHONE NUMBER

Attachment: Claimant Reimbursement Form – Medical Services

## **Request for Reimbursement - Out-of-Pocket Medical Expenses Checklist**

##

|  |
| --- |
| Personal and Injury Information |
| 1. Name
 |  |
| 1. Claim number
 |  |
| 1. Date of Injury
 |  |
| Co-Payments/Medical Services |
| 1. Provider Name and Address
 |  |
| 1. Provider NPI #
 |  |
| 1. Date of Service
 |  |
| 1. CPT Codes
 |  |
| 1. Diagnosis Codes Billed
 |  |
| 1. Paid Amount
 |  |
| 1. Proof of Payment
 | \*Must be attached |

The following definitions are provided for clarity about the supporting documents/information needed:

**E. NPI (National Provider Identifier) Number**: 10-digit number that the clinic or office will have on file for the provider or found at: [https://npiregistry.cms.hhs.gov/search](https://urldefense.com/v3/__https%3A/npiregistry.cms.hhs.gov/search__;!!DVVpH7g!2Lry0Ki7XB9qRYgkbaF04xK2XWVM2WC8gfr8e3HE82S0KavB9JIwBfpUXyHS2UIabBM9zCA-hadmiEKqDkzYyR4$)

**F. Date of Service**: Date you received medical care associated with the charge.

**G. CPT Codes Billed with Billed Amounts**: Numbers identifying the procedure/services provided. These may be given to you by the medical provider or found on the HCFA billing form or superbill.

 **H. Diagnosis Codes:** ICD-10 codes for the medical treatment given. May be given to you by the provider or found on medical records.

**J. Proof of Payment**: Attach a receipt showing the amount you paid the provider.