

# Expanded Benefits (EB) Reimbursement Form

This form must be submitted within six (6) months from the date services were received in order to be considered for reimbursement.

## Step 1: Member information

1. Your Humana ID (HUMID) Number is on your Member ID Card
2. All boxes must be filled out
3. Please submit (1) form per member

<b>Member Name</b>	<b>HUMID (Humana ID)</b>	<b>Medicaid ID</b>
<b>Address</b>		
<b>City</b>	<b>State</b>	<b>ZIP Code</b>
<b>Signature</b>	<b>Print name of Guardian or responsible party (minors only)</b>	

## Step 2: Receipt information

1. Include copies of the original receipt(s) AND proof of payment for each benefit. Tape receipts to a separate page and submit with this reimbursement form.
2. If you are submitting more than two (2) benefits, please provide required information on an additional piece of paper.
  3. Receipt(s) must include breakdown of all purchased items. If your receipt(s) is missing any of this information, please ask the company for a print out that includes the breakdown of information.
4. Remember to keep a copy of the completed claim form and receipt(s) for your records.

<b>Benefit Used</b>	<b>Date Services Received</b>	
<b>Company Providing Service</b>		
<b>Company Address</b>		
<b>City</b>	<b>State</b>	<b>ZIP Code</b>
<b>Receipt(s) Included</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Comments</b>	

## Expanded Benefits (EB) Reimbursement Form

Benefit Used		Date Services Received
Company Providing Service		
Company Address		
City	State	ZIP Code
Receipt(s) Included <input type="checkbox"/> Yes <input type="checkbox"/> No	Comments	
<b>Step 3: Submit with signature</b> <ul style="list-style-type: none"><li>You will have six (6) months from the date services were received to submit for reimbursement.</li><li>Once all sections of this form are completed, please sign and date. Your signature states that you agree all information on this form and the attached receipt(s) submitted is correct.</li></ul>		
<p style="text-align: center;"><b>A decision on your reimbursement request will be made within ninety (90) days of receiving the completed form and receipt(s).</b></p> <p style="text-align: center;"><b>Any additional services received that go over the approved expanded benefit(s) will be the responsibility of the member.</b></p>		
<p><b>For fastest consideration, return this completed form via email or fax with all copies of original receipt(s) to:</b></p> <p>Email: <b>ExpandedBenefitsReimbursement@humana.com</b> Fax: <b>855-510-0041</b></p> <p><b>Mailing Address:</b> Humana Expanded Benefits c/o Expanded Benefits Administrator P.O. Box 3114 Louisville, KY 40201</p>		
<p style="text-align: center;"><b>Please see the benefits section of the Member Handbook for the benefits that can be considered for reimbursement. Your Member Handbook can be found at <a href="http://Humana.com/OklahomaHandbook">Humana.com/OklahomaHandbook</a>.</b></p>		

## Call If You Need Us

If you have questions or need help reading or understanding this document, call us at **855-223-9868 (TTY: 711)**. We are available Monday through Friday, from 8 a.m. to 5 p.m., Central time. We can help you at no cost to you. We can explain the document in English or in your first language. We can also help you if you need help seeing or hearing. Please refer to your Member Handbook regarding your rights.

## Important!

At Humana, it is important you are treated fairly.

Humana Inc. and its subsidiaries do not discriminate or exclude people because of their race, color, national origin, age, disability, sex, sexual orientation, gender, gender identity, ancestry, ethnicity, marital status, religion, or language. Discrimination is against the law. Humana and its subsidiaries comply with applicable Federal Civil Rights laws. If you believe that you have been discriminated against by Humana or its subsidiaries, there are ways to get help.

- You may file a complaint, also known as a grievance:  
**Discrimination Grievances**, P.O. Box 14618, Lexington, KY 40512-4618.  
If you need help filing a grievance, call **855-223-9868** or if you use a **TTY**, call **711**.
- You can also file a civil rights complaint with the **U.S. Department of Health and Human Services, Office for Civil Rights** electronically through their Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or at **U.S. Department of Health and Human Services**, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, DC 20201, **800-368-1019, 800-537-7697 (TDD)**. Complaint forms are available at <https://www.hhs.gov/sites/default/files/ocr-cr-complaint-form-package.pdf>.

Auxiliary aids and services, free of charge, are available to you.

**855-223-9868 (TTY: 711)**

Humana provides free auxiliary aids and services, such as qualified sign language interpreters, video remote interpretation, and written information in other formats to people with disabilities when such auxiliary aids and services are necessary to ensure an equal opportunity to participate.

**Humana Healthy Horizons in Oklahoma is a Medicaid product of Humana Wisconsin Health Organization Insurance Corporation.**

