GOLD KIDNEY HEALTH PLAN

Supplemental Benefit Reimbursement Form Instructions

Use this form to request reimbursement for any expenses paid out of your own pocket if you were unable to utilize your Alivi Gold Kidney Prepaid Visa® Card at the time of payment. This covers expenses related to supplemental benefits including dental, vision, or hearing services, Gold Perks and Gold Perks Plus, healthy food and produce, and transportation including fuel and rideshare services.

Gold Kidney can only provide reimbursement for services performed **during your period of eligibility as an active Gold Kidney Health Plan member**. Reimbursement is limited to funds that were **available during the dates of service**. Purchases and services must be made from **participating providers or vendors** to be eligible for reimbursement.

Instructions

For vision, dental, and hearing services reimbursement:

1. The itemized bill and receipt of payment from the provider are required.
    - An itemized bill includes the following information: date of service, service or procedure code (description of the procedure or service), charges and payments made, and the provider's full name, address, and phone number.
    - An estimate or a balanced due statement from the provider is **not acceptable,** and the claim cannot be processed.
    - A credit card statement is **not an acceptable** receipt of payment.
2. Complete the entire form on the following page
    - Please use **one** claim form for each claim you are submitting.

For Gold Perks and Gold Perks Plus, transportation, fuel and rideshare, and healthy food and produce reimbursements:

1. A receipt with qualifying items purchased must be submitted.
    - The receipt must include the name of the vendor/merchant, the date of service, items or services purchased, charges, and payment made.
    - A credit card statement is **not acceptable** proof of purchase.
2. Complete the entire form on the following page
    - Please use **one** claim form for each claim you are submitting.

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Submit the completed form and required attachments indicated to Gold Kidney Health Plan:

Mail: Gold Kidney Health Plan
ATTN: Quality Department
P.O. Box 285, Portsmouth, NH 03802

Fax: (866) 537-0536
Email: quality@goldkidney.com

Section 1: Member information		
Member Name:	Member ID #:	
Mailing Address:		
City:	State:	ZIP:

Section 2: Service / Purchase Category *(select one):*	
☐ Vision ☐ Dental ☐ Hearing ☐ Transportation ☐ Food and Produce ☐ Fuel and Rideshare ☐ Gold Perks / Gold Perks Plus	Date of Service / Purchase: __ __ / __ __ / __ __ __ __
Provider/Vendor Name:	
Provider Location:	

Section 3: Reason you were unable to use your Alivi Gold Kidney Prepaid Visa® Card

To expedite your claim, proof of purchase and/or itemized receipt are required. Please be sure the information on the receipt matches the information on this form.

Member Signature: _____ **Date:** _____