NaviCare® SCO and HMO SNP Save Now card reimbursement form

Did you forget to use your Save Now card when paying for your eligible items?

What does my Save Now card cover?

Each calendar quarter you get **$162** to spend on items **to keep you healthy,** such as cold/allergy medicine, pain relievers, probiotics, and more. Plus you get **$50** each calendar quarter **to buy food and personal care items** such as soap, shampoo, fruits, veggies, and more. That's **$848 per year** to buy items you need.

Make your purchases at stores like CVS Pharmacy, Family Dollar, and Walmart. You can also order items by phone or online, with free home delivery.

When do I use this form?

Complete the form on the back of this flyer and return it to us if you have paid for any item(s) covered by your Save Now card, but did not use your Save Now card to pay for eligibile item(s).

How do I get my reimbursement?

- Complete the form on the back of the flyer.
- Submit dated original receipts and copies of bank/credit card statements showing the charge for your items.

We accept multiple receipts and requests on one form, so you can be reimbursed all at once! Reimbursement is subject to approval by Fallon Health. Please allow 4-6 weeks from the date we get the completed form for payment.

fallonhealth

1-877-700-6996 (TRS 711)
8 a.m.–8 p.m., Monday–Friday
(Oct 1-March 31, seven days a week.)

fallonhealth.org/navicare

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NaviCare® Save Now Card Reimbursement Form

Use this form to request a reimbursement for eligible items.

Ways to get reimbursed:

1. **Mail completed form to:**
   Fallon Health,
   P.O. Box 211308, Eagan, MN 55121-2908
2. **Email completed form to:**
   reimbursements@fallonhealth.org

MEMBER information			
Name:		Telephone number: ( )	
Date of birth:	NaviCare ID card number:		
REQUESTOR information			
Is this form being completed by a Fallon Health staff member on the member's behalf? ❑ Yes ❑ No			
Is the requestor someone other than the member? ❑ Yes ❑ No			
Name of the person requesting the reimbursement:			
Relationship to enrollee:		❑ AOR/PRA ❑ POA	
Requestor's address:		Requestor's telephone number:	
Has the member approved that the reimbursement check be issued to the requestor? ❑ Yes ❑ No			
PURCHASE information			
Retailer(s) where item(s) was purchased:			
City/State of retailer(s):			
Date of purchase:	Service CPT code: **A9150**	**Charge**	**Amt. Paid**
Description of item(s) purchased:			

Certification and authorization

I certify that the information above is correct to the best of my knowledge. I am claiming reimbursement only for eligible expenses during the applicable benefit year and for eligible members.

Member's or Representative's signature:

_____

Date: _____

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