GOLD KIDNEY HEALTH PLAN

2025 Vision, Dental, and Hearing Services Reimbursement Form

Use this form to request reimbursement for a vision, dental, or hearing service that you paid for out of your own pocket and were unable to utilize your Alivi Gold Kidney Prepaid Visa® Card at the time of payment.

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 service dates. The following Gold Kidney supplemental benefits are **not** eligible for reimbursement:

- Gold Perks and Gold Perks Plus benefits
- Healthy food and produce
- Transportation, including fuel and/or rideshare

Instructions:

1. You must enclose the original itemized bill from your provider. 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 your provider is not acceptable and your claim cannot be processed.
    - To expedite payment of your claim, please be sure that the provider information on the receipt matches the information found on the reimbursement form.
2. Complete the entire form below
    - Please use **one** claim form for each claim you are submitting.

Submit the completed form and attachments indicated above 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 #:	
Address:		
City:	State:	ZIP:
Section 2: Service Provided		
Service *(select one):* ☐ Vision ☐ Dental ☐ Hearing	Date of Service:	
Provider Name:		
Provider Location:		

Member Signature: _____ **Date:** _____