

# NaviCare<sup>®</sup> 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?**

You get \$150 each calendar quarter (up to \$600 a year) to buy things like toothbrushes, pain relievers, probiotics and more. Buy items in a store or online with free shipping.

### **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 that item(s).

### **How do I get my reimbursement?**

- Complete the form on the back of the flyer.
- Submit dated original receipts or copies of bank/credit 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 for payment.

**1-800-877-6996**

8 a.m.–8 p.m., Monday–Friday  
(Oct 1–March 31, seven days a week.)

**[fallonhealth.org/navicare](https://fallonhealth.org/navicare)**



# NaviCare® Save Now Card Reimbursement Form

Use this form to request a reimbursement for eligible items such as over-the-counter, health-related items like toothbrushes, pain relievers and probiotics.

## Three 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
3. **Give completed form to your Navigator.**

### MEMBER information

Name:	Date of birth:
NaviCare ID card number:	Telephone number: (       )

### REQUESTOR information

Is this form being completed by a Fallon Health staff member on the member's behalf? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Is the requestor someone other than the member? <input type="checkbox"/> Yes <input type="checkbox"/> No	Name of the person requesting the reimbursement:
Relationship to enrollee:	<input type="checkbox"/> PRA <input type="checkbox"/> POA
Requestor's address:	Requestor's telephone number:
Has the member approved that the reimbursement check be issued to the requestor? <input type="checkbox"/> Yes <input type="checkbox"/> No	

### PURCHASE information

Facility (or facilities) where item(s) were purchased:			
NPI or Tax ID # of facility:			
Date of service:	Service CPT code: <b>A9150</b>	<b>Charge</b>	<b>Amt. Paid</b>
Description of service:			

### FALLON STAFF ONLY: Reimbursement verification/decision

Date received from Claims:	
Is the item(s) being requested covered under the Save Now OTC benefit? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Does the member's OTC card have enough funds available to cover reimbursement? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Was a NaviCare Program Manager notified to deduct reimbursement from OTC card? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Approved reimbursement amount:	Ineligible reimbursement amount:

### 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: \_\_\_\_\_

