Michigan State University Counseling & Mental Health Services Fund

ATTESTATION OF ELIGIBILITY & REIMBURSEMENT REQUEST

SECTION 1 – PERSONAL INFORMATION & INSURANCE

Personal Information of Individual Seeking Reimbursement

Last Name ______________________ First Name ______________________ Middle Initial ______

Date of Birth ______________________ Last Five SSN ______________________

Address ______________________ Email Address ______________________

City ______________________ State ______________________ ZIP ______________

What is your relationship to the person who received treatment from former doctor Larry Nassar at a MSU health clinic or as a MSU student-athlete?

Patient/Survivor. I am the person who received treatment from former doctor Larry Nassar at a MSU health clinic or as a MSU student-athlete (patient/survivor).

Spouse/Parent/Legal Guardian. I am the Spouse, Parent or Legal Guardian during or after the time the patient/survivor received treatment from former doctor Larry Nassar.

Patient Survivor *(Required)*

This section relates to the person who initially received treatment from former doctor Larry Nassar

Last Name ______________________ First Name ______________________ Middle Initial ______

Date of Birth ______________________ Last Five SSN ______________________

Address ______________________ Email Address ______________________

City ______________________ State ______________________ ZIP ______________

Insurance Information *(Please check one)*

☐ **I have insurance**

Insured Person ______________________ Group # ______________________

Insurance Company ______________________ Policy # ______________________

Must submit a copy of Explanation of Benefits (EOB) from all insurance carriers that covered these services along with all completed pages of this Attestation of Eligibility and Reimbursement Request.

☐ **I am not insured.** I attest I am uninsured and have not received reimbursement for services during the time in which the outpatient mental health services were provided. I acknowledge that the reimbursement for an uninsured eligible recipient is the lesser of the reasonable and customary allowance as defined by the fund or actual expenses incurred.

Must submit the paid invoice(s) or superbill(s) from behavioral health provider along with all completed pages of this Attestation of Eligibility and Reimbursement Request.

SECTION 2 – ATTESTATION OF ELIGIBILITY

Attestation

I attest that I am one of the following (Please check one)

Patient. I am the patient who received treatment from former doctor Larry Nassar at a MSU health clinic or as a MSU student-athlete.

Spouse/Parent/Legal Guardian. I was the Spouse, Parent or Legal Guardian of the patient listed above during or after the time she received treatment from former doctor Larry Nassar at a MSU health clinic or as a MSU student-athlete.

I understand that the Counseling and Mental Health Services Fund ("fund") is set up to provide financial support to patients, patient's parents or legal guardians, and a patient's spouse for certain out-of-pocket expenses, including co-pays, deductibles, or co-insurance, related to outpatient mental health services until the fund is depleted.

I am requesting reimbursement for out-of-pocket expenses resulting from the outpatient mental health services I have received to treat the outcome of the abuse by former doctor Larry Nassar. I understand that reimbursement is subject to the eligibility requirements of the fund.

I understand that the fund is a payor of last resort. I will not submit any claims for reimbursement unless all other insurance coverage has been exhausted.

By submitting this reimbursement request, I agree and certify that I will comply with all applicable federal and state laws and any applicable program, policy, procedure of the fund.

I attest that all information submitted in this Reimbursement Request is accurate and complete.

Submission of false claims, statements, or documents or concealment of a material fact may be prosecuted under applicable federal and state laws.

Signature____ Date_____________________

Printed Name____

Continue to next page to complete a Reimbursement Request.

SECTION 3 – REIMBURSEMENT REQUEST

Complete this form with assistance from your mental health provider.

Submit a separate reimbursement form for each different provider. All fields are required.

Provider Name ____

Provider Address ______________________________ Email Address ______________________________

City______________________________ State____________________ ZIP______________

Provider Tax ID ______________________________ NPI ______________________________

For those with insurance:
Submit a copy of Explanation of Benefits (EOB) from all insurance carriers that covered these services along with all completed pages of this Attestation of Eligibility and Reimbursement Request.

For those without insurance:
Submit the paid invoice(s) or superbill(s) from behavioral health provider along with all completed pages of this Attestation of Eligibility and Reimbursement Request.

Diagnosis Code (ICD-10)	Date of Service (MM/DD/YYYY)	Place of Service	Service Code (CPT)	Units	Total Charge	Requested Reimbursement*
					$	$
					$	$
					$	$
					$	$
					$	$
					$	$

*Eligible out-of-pocket expense, such as co-pay, deductible or co-insurance. See eligibility requirements at www.ndbh.com/MSUCounselingFund.

Instructions for Reimbursement Requests

Individuals with Insurance: Email a copy of all insurance carriers' Explanation of Benefits (EOB) along with all completed pages of this Attestation of Eligibility & Reimbursement Request.
Add the words "**Reimbursement Request_[your name]**" in the **Subject** line of the email and send all documents to: Reimbursements-MSUFund@ndbh.com.

Individuals without Insurance: Email a copy of the provider's invoice along with all completed pages of this Attestation of Eligibility and Reimbursement Request. Need to know how you will be reimbursed? Refer to "Understanding How Reimbursement is Calculated for Those Without Insurance" located at www.ndbh.com/MSUCounselingFund.
Add the words "**Reimbursement Request_[your name]**" in the **Subject** line of the email and send all documents to: Reimbursements-MSUFund@ndbh.com.

Have questions completing this form? Visit www.ndbh.com/MSUCounselingFund or call
New Directions' Customer Service for MSU at 877-250-6408, Monday-Friday, 8:30 a.m. – 6:00 p.m. ET.

New Directions is an independent agent hired to serve as administrator for Michigan State University's Counseling & Mental Health Services Fund.