RCAB Member Reimbursement Form
Natural Family Planning Visits

TUFTS Health Plan
No one does more to keep you healthy.

(Please print clearly, complete all sections and sign. Retain a copy of all receipts and documents for your records.)

1. Patient's Tufts Health Plan #
☑ POS

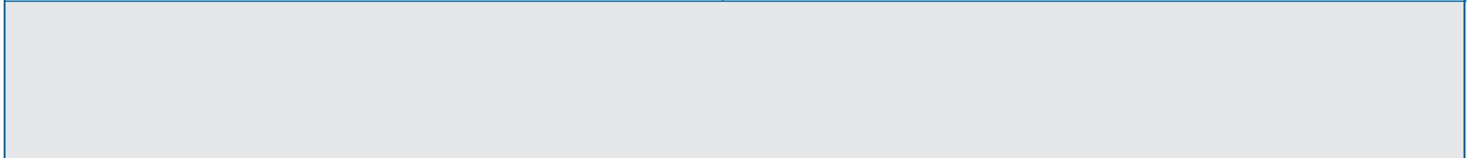
2. Patient's Name (Last, First, Middle Initial)

3. Patient's Date of Birth / /
sex: ❑ M ❑ F

4. Patient's Relationship to Subscriber
❑ Self ❑ Spouse ❑ Child ❑ Other

5. Subscriber's Name:
Address:
Telephone: ( ) -

6. Provider's Name:
Address:
Telephone: ( ) -

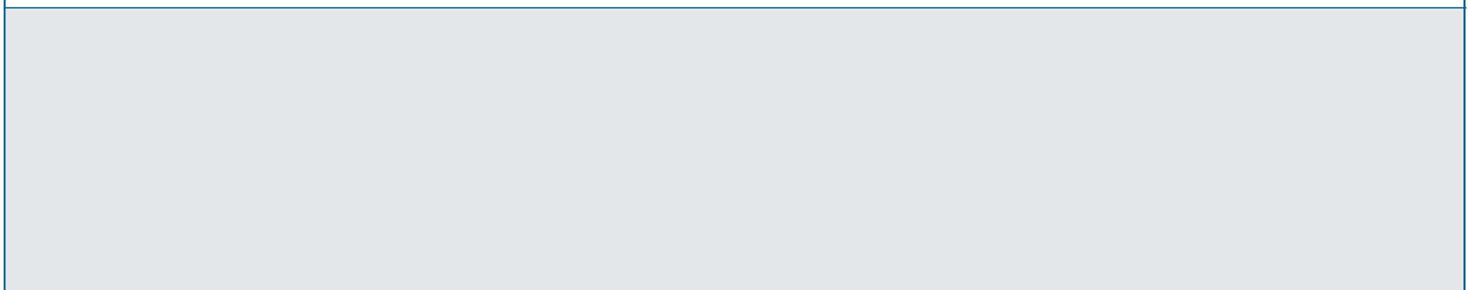


7. DIAGNOSIS:
Diagnosis Code: V25.04

8.

A	B	C
Date(s) of service	Procedure code	Amount paid
	99401 – preventive medicine counseling and/or risk factor reduction intervention(s)	

9. Total Amount Paid: ___________



10. Signature is required
I attest that the above information is accurate and complete. ______________________________

INTERNAL USE ONLY

Representative's Name/Extension: Corporate Receipt Date:

Please submit this form and all documentation to:

TUFTS HEALTH PLAN
MEMBER REIMBURSEMENT CLAIMS, PO BOX 9191
WATERTOWN, MA 02471-9191

Proof of service and payment

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DESCRIPTION *(please indicate the type of NFP counseling provided)*	AMOUNT PAID
❑ Cross-Check Method	______________
❑ Couple To Couple League Sympto-Thermal Method	______________
❑ Billing Method	______________
❑ Creighton/Fertility Care Method	______________
TOTAL	$

I certify that instruction/counseling in Natural Family Planning has been provided to the above-referenced individual and that the payment indicated above has been received in full.

____
Natural Family Planning Counselor Signature

____
Date