

PAID OUT OF POCKET?

Filing for reimbursement

Here's how to get paid back.**We never want you to pay out of pocket for the plan's portion.**

Call PERMA FAIR first. We can provide a **PERMA FAIR electronic payment card** to pay the provider.

Already paid the full amount? Here's how to get reimbursed.

FILE WITHIN

364

days from the date of service. Later claims can't be paid.

1**Ask for a Superbill before you leave**

It must list the patient name, date of service, diagnosis and procedure codes, amount paid, and the provider's Tax ID, name and billing address.

2**Complete, sign and date the claim form**

Fill in every section (mark "N/A" if it doesn't apply). A spouse or adult dependent must also sign.

3**Attach proof of payment and check the box**

Otherwise, payment goes to the provider, not you.

4**Send it to Lucent Health**

Fax: 615-255-6654 (Attn: Member Reimbursement Team)

Email: MedicalMemberReimbursement@lucenthealth.com

Mail: P.O. Box 211466, Eagan, MN 55121

For claim status, call the number on your Benefits ID Card.

Get the claim form & examples

See the next page for examples of a complete Superbill and claim form, or look for the claim form on your Lucent Health member portal.

Reimbursement covers the plan's portion only; your own cost share still applies.

Need Help?

Call the Member Number on your Benefits ID Card and **select Option 2** for PERMA FAIR.

REIMBURSEMENT EXAMPLES

What a complete claim looks like

SAMPLE DATA ONLY

1. Provider Superbill

Ask for this before you leave.

Riverbend Family Practice**SUPERBILL**

210 Oak Street, Cherry Hill, NJ 08002 · 856-555-0400

Billing: PO Box 4412, Cherry Hill, NJ 08034 · Tax ID (TIN) 22-3456789 · NPI 1487562930

Patient Name	Date of Birth	Date of Service	Statement Date
Jane Doe	04/12/1986	07/29/2026	07/29/2026

DATE	CPT / HCPCS	DESCRIPTION OF SERVICE	DX	CHARGE
07/29/2026	99396	Preventive medicine visit, established patient, 40–64 years	Z00.00	\$268.00
07/29/2026	36415	Collection of venous blood by venipuncture	E78.5	\$50.00

SIX THINGS THE SUPERBILL MUST SHOW

- | | |
|---|--|
| ☒ Patient name | ☒ Amount paid |
| ☒ Date of service | ☒ Provider TIN, name and |
| ☒ Diagnosis codes | billing address |
| ☒ Procedure codes | |

Total Charges **\$318.00** Amount Paid by Patient **\$318.00** Balance **\$0.00**
Paid in full at time of service. Receipt issued and attached as proof of payment.
Provider signature: *A. Whitfield, MD*

2. Completed claim reimbursement form

Every section filled in, signed and dated.

IMPORTANT — READ CAREFULLY

- Complete this form in its entirety.
- Indicate “Not Applicable” or “N/A” if a section does not apply.
- Be sure to sign and date this form at the bottom.
- Include the provider’s “Superbill” showing patient name, date of service, diagnosis and procedure codes, amount paid, and billing address.
- Amounts paid by the Plan go to the provider unless you attach proof of payment.
- Mail to P.O. Box 211466, Eagan, MN 55121; fax 615-255-6654; or email MedicalMemberReimbursement@lucenthealth.com.

SECTION I: INSURED / SUBSCRIBER INFORMATION

Full Name (as it appears on your paycheck)

Jane Doe

Group Number

HS-00000

Member ID

LH00000000

Date of Birth

04/12/1986

Employer

Heartshare Human Services of New York**SECTION II: CLAIMANT (PATIENT) INFORMATION**

Patient Name

Jane DoeRelationship ☒ Self ☐ Spouse ☐ Child**SECTION III: PROVIDER INFORMATION**

Provider Name and Address

Riverbend Family Practice, Cherry Hill, NJ

Tax ID (TIN)

22-3456789**SECTION IV: ACCIDENT, INJURY, OR WORK RELATED ILLNESS**Due to accident, injury or work related illness? ☐ Yes ☒ **No — skip to Section V****SECTION V: AUTHORIZATION & SIGNATURE**

I/We certify the above information is true and correct...

Employee Signature **Jane Doe** Date **08/14/2026****ATTACHED SUPERBILL** DOS 07/29/2026 · Paid \$318.00 · ☒
Receipt attached**Need Help?**Call the Member Number on your Benefits ID Card and **select Option 2** for PERMA FAIR.