

WHAT IF I ALREADY PAID OUT OF POCKET?

Filing for Reimbursement



364

days from the date of service for Lucent Health to receive your claim. Later claims can't be paid.

Claim form and Superbill examples

Scan the QR code below or visit the [Caron benefits website](#).



1

Get 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

The Lucent Health Plan Claim Reimbursement Form is on the Caron benefits website. Unsigned or incomplete forms are returned.

3

Attach proof of payment and check the box

Without both, any payment goes to the provider instead of you.

4

Send it to Lucent Health

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

MedicalMemberReimbursement@lucenthealth.com.

CLAIMS SUBMISSION WITH LUCENT HEALTH

Example: Provider Superbill

Ask for a Superbill before you leave. It must show the patient name, date of service, diagnosis and procedure codes, amount paid, and the provider's Tax ID, name and billing address. Sample data only.

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 Jane Doe		Date of Birth 04/12/1986	Date of Service 07/29/2026	Statement Date 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	
Diagnosis codes: Z00.00 — routine general medical examination · E78.5 — hyperlipidemia, unspecified		Total Charges \$318.00	Amount Paid by Patient \$318.00	Balance \$0.00	
SIX THINGS THE SUPERBILL MUST SHOW ☒ Patient name ☒ Date of service ☒ Diagnosis codes ☒ Procedure codes ☒ Amount paid ☒ Provider tax ID, name and billing address			Paid in full at time of service. Receipt issued and attached as proof of payment. Provider signature A. Whitfield, MD		

Example: Completed Claim Reimbursement Form

Fill in every section, then sign and date it. Attach the Superbill and proof of payment, and send it to Lucent Health by fax (615-255-6654) or email (MedicalMemberReimbursement@lucenthealth.com). Sample data only.

IMPORTANT — READ CAREFULLY					
1. Complete this form in its entirety.		2. Indicate "Not Applicable" or "N/A" if a section does not apply.		3. Be sure to sign and date this form at the bottom.	
4. Include the provider's "Superbill" showing patient name, date of service, diagnosis and procedure codes, amount paid, and provider tax ID, name and billing address.		5. Amounts paid by the Plan go to the provider unless you attach proof of payment.		6. Mail to P.O. Box 211466, Eagan, MN 55121; fax 615-255-6654 (Attn: Member Reimbursement Team); or email MedicalMemberReimbursement@lucenthealth.com .	
SECTION I: INSURED / SUBSCRIBER INFORMATION			SECTION III: PROVIDER INFORMATION		
Full Name (as it appears on your paycheck) Jane Doe	Group Number M0-40817	Member ID LH88472913	Provider Name and Address Riverbend Family Practice, Cherry Hill, NJ		Tax ID (TIN) 22-3456789
Date of Birth 04/12/1986	Number & Street 118 Larchmont Ave		SECTION IV: ACCIDENT, INJURY, OR WORK RELATED ILLNESS		
City Cherry Hill	State NJ	Zip Code 08002	Due to accident, injury or work related illness? ☐ Yes ☒ No — skip to Section V		Date Occurred N/A
Email Address jane.doe@email.com	Telephone Number 856-555-0142		SECTION V: AUTHORIZATION & SIGNATURE		
Employer Richard J. Caron Foundation			I/We certify the above information is true and correct, and authorize providers rendering care to furnish Lucent Health with full information regarding treatment. A claim for a spouse or adult dependent child must also carry their signature.		
SECTION II: CLAIMANT (PATIENT) INFORMATION			Employee Signature Jane Doe	Spouse / Adult Dependent N/A	Date 08/14/2026
Patient's Name Jane Doe	Relationship ☒ Self ☐ Spouse ☐ Child		ATTACHED SUPERBILL		
Gender ☐ Male ☒ Female	Date of Birth 04/12/1986		DOS 07/29/2026 · Dx Z00.00, E78.5 · CPT 99396, 36415 · Paid \$318.00 · Riverbend Family Practice, TIN 22-3456789, PO Box 4412, Cherry Hill, NJ 08034		
			☒ Receipt attached Fax 615-255-6654 Attn: Member Reimbursement Team		