



MEMBER REIMBURSEMENT FORM

MEMBER'S LAST NAME	FIRST NAME	MI	DATE
ADDRESS (STREET)	CITY	STATE	ZIP CODE
HOME PHONE #	MEMBER ID #		

REQUIRED REIMBURSEMENT INFORMATION

(Without this information request cannot be processed)

1.) PRESCRIPTION DRUGS

DATE OF SERVICE	AMOUNT OF BILL \$		
DRUG STORE NAME			
ADDRESS (STREET)	CITY	STATE	ZIP CODE

ATTACH THE FOLLOWING: Pharmacy cashier's receipt, pharmacy statement indicating name of drug, dosage, amount supplied, cost, prescribing physician.

2.) FOR ALL OTHER PROVIDER(S) OF SERVICES (DOCTORS, HOSPITALS, ETC.).

The following specific information is required and is available from the billing provider of service

DATE OF SERVICE	PHYSICIAN BILLING CODES	PROVIDER TELEPHONE #	
AMOUNT BILLED BY PROVIDER OF SERVICE \$	AMOUNT PAID BY MEMBER \$	PROVIDER TAX ID #	
PROVIDER ADDRESS (STREET)	CITY	STATE	ZIP CODE

• **Proof of Member's payment (front and back copy of check, credit card, receipt of Doctor's bill indicating amount paid by member).**

• **PCP referral form attached (when applicable).**

3.) REASON YOU ARE REQUESTING THIS REIMBURSEMENT?

(Attach additional sheet if necessary).

This form is not a claim form and should only be used for reimbursements of covered services.