Direct Member Reimbursement Form

INSTRUCTIONS: You will need your physician or other healthcare provider to assist and supply information in completing this form, including the procedure code(s) and diagnosis codes(s), if available.

- Attach medical records and proof of payment (ex: payment receipts or a copy of both the front and back of a cashed check) for each supply or service requested for reimbursement. Any missing information may result in a processing delay or denial of the request)
- A separate form must be completed for each individual requesting reimbursement
- Retain a copy of this reimbursement form and all receipts for your records

Member Information

LAST NAME		FIRST NAME		MI
MEMBER ID #	BIRTHDATE (MM/DD/YYYY)		PHONE NUMBER	
MAILING ADDRESS	CITY		STATE	ZIP

Provider Information

NOTE: This section must be completed. Please contact your health care provider for assistance.

LAST NAME		FIRST NAME	
TAX ID #			
STREET ADDRESS	CITY	STATE	ZIP

Service Information

Detail Description for Medical Reimbursement:

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Date of Service	Service Location	Procedure Codes	Number of Units	Diagnosis Codes	Amount Paid
					$
					$
					$
					$
				Total Amount Paid	$

The time limit to submit a request for review is one year from the date of service, this and other important information may be found in Chapter 7 of your explanation of coverage handbook. Please allow us 60 calendar days to complete the processing of your request. Services that were rendered outside of the United States may take longer. **THIS IS NOT A GUARANTEE OF PAYMENT.** Actual payment for covered services will be paid at the appropriate level according to your plan benefit.

Mail or deliver this completed form and all documents to PO Box 3459, Spring Hill FL, 34611
Fax: (800) 303-2607

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