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 cancelled 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 payment, this and other important information may be found in Chapter 7 of your explanation of coverage handbook. Please allow us 60 business 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, hand-deliver or fax this completed form and all documents to 1244 Mariner Blvd, Spring Hill FL, 34609
Fax: (352) 835-7169