



# Member Reimbursement Claim Form



Before filling out this form, please review the instructions on the next page. If you have any questions or need assistance with this form, please call our Member Services department at 800-700-3874. Fill out a separate form for each member who is asking for reimbursement for covered services and for each doctor and/or facility.

To avoid delays, please include the following information with this form:

- Copy of itemized bills showing services received
- Proof of payment with the date and how you paid (check, credit card)

**Mail completed form to:**

Central California Alliance for Health Attn: Member Services, 1600 Green Hills Road, Suite 101 Scotts Valley, CA 95066

**1. This reimbursement claim is for:**

- ☐ Medical Services  
☐ Pharmacy Services  
☐ Other Services

**2. Did you have another health insurance at the time you received this service?**

- ☐ Yes (Attach an Explanation of Benefits from your other health insurance plan with this form.)  
☐ No

**3. Member Information:**

a. Alliance Member ID number: \_\_\_\_\_

b. Member name: \_\_\_\_\_

c. Social Security number (SSN#): \_\_\_\_\_

d. Date of Birth (MM/DD/YYYY): \_\_\_\_\_

e. Phone number 1: \_\_\_\_\_ ☐ Home ☐ Mobile

f. Phone number 2: \_\_\_\_\_ ☐ Home ☐ Mobile

g. Member's Email Address: \_\_\_\_\_ (Optional)

h. Member's Mailing Address (Please include Apartment #) ☐ Check here if it's a new address

Street: \_\_\_\_\_ Apt/Spc # \_\_\_\_\_ City: \_\_\_\_\_ Zip \_\_\_\_\_

**4. Services received for which you paid:**

a. Date of services (MM/DD/YYYY): \_\_\_\_\_

b. Name of doctor and/or facility: \_\_\_\_\_

c. Phone number of the doctor and/or facility: \_\_\_\_\_

d. Address of doctor and/or facility:

Street: \_\_\_\_\_ Suite # \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

e. Description of the service received or nature of illness or injury:

\_\_\_\_\_

f. Amount requested to be reimbursed: \$ \_\_\_\_\_

**5. Reason for filing this Member Reimbursement Claim Form:**

By signing below, I certify that, to the best of my knowledge, the information on this Member Reimbursement Claim Form is true and correct. I authorize the release of any medical information necessary to process this claim.

Signature

Print Name

Date (MM/DD/YYYY)

X



# Member Reimbursement Claim Form



## Instructions: How to fill out the Member Reimbursement Claim Form

Central California Alliance for Health (the Alliance) will pay you directly if you had to pay for covered services. Services may be reviewed for medical necessity before we pay for them. If approved for payment, the Alliance will send you a check. If services are not eligible for reimbursement, the Alliance will send you a letter.

**Please complete the form.** Be sure to attach a copy of itemized bills showing services received. Attach proof of payment with the date and how you paid (check, credit card).

### FOLLOW THESE STEPS CAREFULLY

#### Step 1: Complete all sections on the form.

##### Section 1 Reimbursement claim:

Pick the type of service you paid for or write in the service name.

##### Section 2 Other insurance?

If you had other health insurance coverage at the time you received the services, select yes. You will need the Explanation of Benefits form from your other health insurance plan. This will show what the other insurance paid. Otherwise, select no.

##### Section 3 Member information:

Write down the Member ID number and other information.

##### Section 4 Services for which you paid:

Write down the services you received for which you paid.

##### Section 5 Reason for Filing:

Write down the reason why you paid for the services.

#### Step 2: Attach itemized bills with this form. Each itemized bill must show all of the following:

• Date of the service	• Charge for each service
• Place of service	• Doctor or provider's name and address
• Description of each service	

To process your claim quickly, it is helpful if the diagnosis is shown on the bill, but not required.

#### Step 3: Mail the completed form and support documents. To avoid delays, please include:

- A copy of itemized bills showing the services received
- Proof of payment that shows the date and how you paid (receipt such as a check or credit card).
- Explanation of Benefits, if you have another health insurance plan

#### Mail completed form and documents to:

Central California Alliance for Health Attn: Member Services,  
1600 Green Hills Road, Suite 101 Scotts Valley, CA 95066

If you have questions, please call our Member Services department at **800-700-3874**. If you need language assistance, we have a special telephone line to get an interpreter who speaks your language. For the Hearing or Speech Assistance Line, call **800-735-2929 (TTY: Dial 7-1-1)**.