Enrollee Member Request for Reimbursement Claim Form

REASON FOR REIMBURSEMENT

This claim form can be used to request reimbursement of covered expenses. You may select one of the reasons below to tell us more about your request. Note that the use of a claim form, such as this Enrollee Member Request for Reimbursement Claim Form, is not required to receive a reimbursement.

☐ I did not use my medical ID card
☐ Non-participating provider *(Please explain)*

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☐ Vision ☐ Hearing Aids

☐ Primary coverage is with another insurance carrier. Please provide explanation of benefits (EOB) or denial letter from the primary insurance carrier

☐ I was waiting for a medical referral or approval
☐ Traveling out of the country
☐ Other

Explanation:______________________________________

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ENROLLEE INFORMATION

ID number (On the front of your Brandman Health Plan ID card):____________________________

Enrollee name: ____ Enrollee sex: ☐ Male ☐ Female

Enrollee date of birth date: Month _____________Day_____ Year_______ Daytime phone#: ______________

Are you the: ☐ Enrollee or ☐ Beneficiary Representative

If you are the Beneficiary Representative, please include the required Appointment of Representation (AOR), Power of Attorney or Executor of Estate form. The AOR form can be found at: www.cms.gov/medicare/cms-Forms/downloads/cms1696.pdf

ENROLLEE CERTIFICATION

I attest that the enrollee information entered on this form is correct, that the enrollee named is eligible for the benefits and that the enrollee has received the service described. I also attest that the treatment received is not for treatment of an on-the-job injury. I also authorize release of all information pertaining to this claim to the plan administrator or its designees. Any person who knowingly and with intent to defraud any insurance company or other person: (1) files an application for insurance or statement of claim containing any materially false information; or (2) conceals for the purpose of misleading, information concerning any material fact thereto, commits a fraudulent insurance act which is a crime.

Enrollee signature: ____Date:_______________

Beneficiary Representative: (If applicable) ____________________________________Date:_______________

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MEDICAL CLAIM INFORMATION	
Date of Service:	Description of Service:
Providers Name	Amount Paid: $
Provider's Address	Provider's Phone #:
Provider's Tax Identification Number (TIN)	Provider's National Provider Identifier (NPI) Number

INSTRUCTIONS

1. Fully complete all sections of this form. Submit a separate form for each request.
2. Sign and date the Enrollee Certification statement in the area provided.
3. If you do not have a detailed receipt for each service related to your request, you can ask your doctor or provider for a replacement receipt or a patient printout. The receipt must show proof of payment.
4. If you are submitting this request for someone other than yourself, please include the required Appointment of Representation (AOR), Power of Attorney or Executor of Estate form. The AOR form can be found at: www.cms.gov/medicare/cms-Forms/downloads/cms1696.pdf
5. Claims missing information may be denied. Remember to send detailed receipts, or invoice printout. Please note that cash register receipts alone are not acceptable.
6. If you need help completing this form, contact customer service at 1-888-697-5662
7. Include any prescription you have pertaining to this request. Make a copy of your prescription receipts. Keep a copy for your records.
8. Mail your request to: **Brandman Health Plan Attn: Member Services P.O. Box 18650 Encino, CA 91416.**
9. Questions? Please call the customer service number located on your ID card.
10. Feel free to include any additional information here to help us better review your request:

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