Member Reimbursement Request Form
Medical Services

COMMUNITY CARE HEALTH

Purpose

The purpose of this form is to request reimbursement from Community Care Health for costs for covered medical services.

Instructions

1. You must submit your reimbursement request within 180 days of the date of service. Reimbursement for approved charges will be mailed within 30 days of receipt of complete documentation. Any applicable deductible, copay, or coinsurance will be deducted from your refund.

2. Complete a separate form for each member who is requesting reimbursement. Only one form is needed per member.

3. The member who received the medical services must sign this form. If the member is under 18 years old, the form must be signed by the parent or guardian.

4. Send this completed form and the following documents to Community Care Health. Keep copies of all items sent to Community Care Health:
   - Ask your provider to give you a Superbill or Invoice that includes all of the following for each date of service. **IMPORTANT**: This information must be on the Superbill as it is required to process the claim. Missing information can result in a delay or non-payment of the claim. Please be sure the information is clear and readable.
     - Patient Name
     - Diagnosis codes
     - Procedure Codes (CPT, HCPC) - with any applicable modifiers
     - Units for each procedure code
     - The billed amount for each procedure code
     - Place of service code
   - Proof of payment in the form of copies of: an itemized receipt, the front and back of a canceled check, or a credit card statement.
   - Medical records are required for reimbursement for all services except emergency room or urgent care services.

Submit

Please submit the finished form and required documents by mail:

P.O. Box 45016
Fresno, CA 93718

Member Information (Complete this section for all reimbursement requests.)			
First name	Last name		Middle initial
ID#	Phone #	Birth date (mm/dd/yyyy)	
Home Address, City, State, Zip			
Please explain the reason you had to seek medical services.			
Were services received as a result of an accident? ☐ Yes ☐ No		If yes, give the date of the accident:	
Were services received as a result of an injury at work? ☐ Yes ☐ No		If yes, give the date of the incident:	
Parent/Guardian enrolled in Community Care Health (Complete this section if the member is under 18.)			
First name	Last name		Middle initial
ID#	Phone #	Birth date (mm/dd/yyyy)	
Home Address, City, State, Zip			
Other Health Coverage (Complete this section if you have other health coverage.)			
Other health plan name:	Health plan phone number:	Effective date of other coverage (mm/dd/yyyy):	
Policy holder's name:	Policy holder's ID#:	Policy holder's birth date:	
Type of coverage: ☐ Medical ☐ Dental ☐ Vision ☐ Other	Type of policy: ☐ Self only ☐ Self and spouse ☐ Family ☐ Other		

Certification Statement

I certify that the above information is true and the attached material is correct and unaltered and that the expenses were incurred by the patient named above. I understand all documents submitted become the property of Community Care Health and will not be returned. I understand that if I submit false receipts or fraudulently altered documents, I may be disenrolled from Community Care Health and/or subject to civil or criminal penalties. I authorize the release of any information needed to review or process this request.

_____ X _____ _____

Member's name (Parent/Guardian if child) Member's signature (Parent/Guardian if child) Date

If you need assistance, we're here to help. Call Community Care Health Customer Service at 1 (559) 724-4995, Monday through Friday, 8 a.m. to 6 p.m., or email us: customerservice@communitycarehealth.org.

IMPORTANT: Can you read this letter? If not, we can have somebody help you read it. You may also be able to get this letter written in your language. For free help, please call Community Care Health right away at 1 (559) 724-4995.

IMPORTANTE: ¿Puede leer esta carta? Si no le es posible, podemos ofrecerle ayuda para que alguien se la lea. Además, usted también puede obtener esta carta en su idioma. Para ayuda gratuita, por favor llame a Community Health Care inmediatamente al 1 (559) 724-4995.