Member Request For Medical Reimbursement Form

Read carefully before completing this form:

1. Member Request for Medical Reimbursement form: All boxes must be filled out entirely in order to process. Forms will be sent back to you if there is missing information.
2. Be sure your original receipts are complete. In order for your request to be processed, all receipts must contain the information listed below. Your provider can provide the necessary information if it is not listed on your bill/receipt.
3. Complete a separate form for each provider used and for each member.
4. Submit form and receipts within **90 days** of the date of service.
5. Submit other insurance explanation of benefits (EOB) within **90 days** from the date of service.
6. Request should have all documentation in order by the reimbursement form, provider documentations, receipts and explanation of benefits (if applicable).
7. Keep a copy of the completed form and receipts for your records.
8. Return the completed form and receipt(s) to:

UnitedHealthcare Community Plan
Attention: Member Services Department
1 East Washington Street, Suite 900
Phoenix, AZ 85004

Use this form to submit reimbursement request for the following:

- Co-payments with Medicare or Other Insurance for UnitedHealthcare Community Plan covered services
- Coinsurance and Deductible with Medicare or Other Insurance with UnitedHealthcare Community Plan covered services. If the allowable from the primary insurance is greater than UnitedHealthcare Community Plan request will be denied.

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MEMBER INFORMATION:

AHCCCS ID#:		DATE OF BIRTH:	
FIRST NAME:	MIDDLE INITIAL:	LAST NAME:	
ADDRESS:			
CITY:	STATE:	ZIP CODE:	TELEPHONE:

PROVIDER INFORMATION:

DATE OF SERVICE:	SERVICE RECEIVED:		
PRACTICE NAME:			
PROVIDER LAST NAME:		PROVIDER FIRST NAME:	
ADDRESS:			
CITY:	STATE:	ZIP CODE:	TELEPHONE:

REIMBURSEMENT INFORMATION:

AMOUNT PAID BY MEMBER:	REIMBURSEMENT TOTAL AMOUNT REQUESTED:
REASON FOR REIMBURSEMENT:	