ClarionHealth

Member Reimbursement Form

This form is to be used for reimbursement of covered services provided in accordance with your **Health Plan** benefits. Member or Authorized Representative must complete the reimbursement form and provide all required information for the request to be processed. If you are requesting reimbursement for services provided by multiple providers, a separate form for each provider must be completed. **Please print clearly**.

Medical claims must be submitted within 365 days of the date of service. Failure to submit medical claims within the 365 days would require you to submit a written appeal showing good cause for the delay in filing the claim.
*Do not use this form prescription drug reimbursement. Please use the *Prescription Drug Reimbursement form**

MEMBER INFORMATION	
Member ID:	Request Date:
First Name:	Last Name:
Address (Street, City, State, Zip):	
Phone Number:	Best Time to Reach:
AUTHORIZED REPRESENTATIVE (if applicable)	
First Name:	Last Name:
Phone Number:	Best Time to Reach:
REASON FOR REQUEST (check all that apply)	
☐ Enrollment/Eligibility	☐ Out of area/urgent/emergency request
☐ Out of Network Provider	☐ Other, please describe:
CLAIM DETAILS	
Provider Name:	Provider Address:
Date(s) of Service:	Billed Amount:

Describe the service(s) you received, (e.g. ER visit, lab, equipment, etc.): *Certain services, devices and equipment require prior authorization as a condition of payment. See your Evidence of Coverage for additional information.*
Condition related to either an automotive accident or employment? (Yes or No) If yes, provide incident date.
Reimbursement Amount: $_____ *Please note: Reimbursements made will be less any applicable cost-sharing or copay. Refer to your Evidence of Coverage for additional information.*
SIGNATURE IS REQUIRED
I certify that all information provided on this form is correct and that I personally received these services and request reimbursement according to my plan benefits. I understand that fraudulent acts (including false claims) may be subject to civil or criminal penalties. I also authorize release of eligible information pertaining to this claim(s) to the plan administrator, underwriter, plan sponsor and/or policyholder.
Signature: Date:

Please fax or mail the completed and signed form along with proof of payment and itemized receipt/bill to the address below. Proof of payment must include your name, the provider itemized bill and receipt showing your payment (i.e., Provider Receipt, Credit Card Receipt, Cancelled Check (front and back), etc.). **Keep a copy of this form and your receipts.**

Mail: Clarion Health
Attn: Claims
P.O. Box 21405
Eagan, MN 55121

Fax: 1-312-873-4405

For further assistance, please contact Member Services at 1 (844) 824-8771. TTY: 711. We are open 8:00 am to 8:00 pm Monday through Friday from April 1 – September 30 and 8:00 am to 8:00 pm seven days a week from October 1 – March 31.