Medical Services Claim Reimbursement Form

To qualify for reimbursement you must provide all of the information requested on this form and substantiate proof of enrollment and/or payment.

First Name: _____Last Name:_____

Date of birth:_____/_____/_____ Telephone#_____

Address:_____

City:_____State:_____Zip:_____

Health Plan Name (Found on your ID)_____

Health Plan ID# _____ Health Plan Group#_____

Provider First Name_____ Provider Last Name:_____

Provider Telephone#_____ Provider Tax ID# (if available) _____

Provider Address:_____

Reimbursement request - Please provide a separate claim for each provider of service

☐ **Medical Services - (all other)**

Reimbursement Guidelines:
In order to receive reimbursement, all supporting documentation must be attached to this claim form. Please include an itemized bill/statement from the provider listing the dates of service, service performed, charge and the name of the patient receiving the service. If you have other insurance, please submit the corresponding Explanation of Benefits from your insurance company.

	Date Services were Rendered MO/DAY/YEAR	Name of Provider Service	Patient Name	Amount Billed	Procedure Code	Diagnosis Code
1	___/___/___			$		
2	___/___/___			$		
3	___/___/___			$		
4	___/___/___			$		
5	___/___/___			$		
6	___/___/___			$		

Reimburse: Member ☐ **Provider** ☐

Email your form and documentation to: ClaimsDept@QualcareInc.com

Questions?
Contact Qualcare member services at 1-800-992-6613, Monday through Friday, 8 a.m. to 6 p.m. ET.

Please read the following and then sign below.
I certify that all services for which reimbursement is requested were incurred by myself or my eligible dependents .
All qualifying services will be reimbursed as outlined in my Plan Summary Description.
My signature below affirms that all of the information listed above is complete, accurate and true, to the best of my knowledge.

Signature:_____ Date_____