Member Reimbursement Claim Form

Normally, when you visit a provider for service, the provider notifies your company's plan ("Plan") of the service by billing us. However, there are occasions when the provider requires a member to pay before you receive a covered service. This Member Reimbursement Claim Form was developed for you to notify us of these covered services for which you have paid for and the plan has not already been billed.

Claim Type: ☐ Medical ☐ Prescription ☐ Dental ☐ Vision ☐ Rideshare Transportation

PRIMARY MEMBER INFORMATION		PATIENT INFORMATION	
Member ID Number:	Group Number:	Relationship to Primary Member *(Check applicable box)* ☐ Self ☐ Spouse ☐ Dependent Child ☐ Other _____	
Name *(Last, First, Middle Initial, Suffix)*	Date of Birth *(MM/DD/YYYY)*	Name *(Last, First, Middle Initial, Suffix)*	Date of Birth *(MM/DD/YYYY)*
Address *(Street, City, State, Zip)*		Address *(Street, City, State, Zip)*	

Documentation for each request will need to show **date of service, description of service** provided and **charges**, as well as the **provider's name** and **address.** *IRS guidelines do not allow cancelled checks, credit card receipts, or bank statements to be used as documentation of expenses.*

- Please itemize your expenses to help facilitate proper processing. If you have more expenses than this form allows, please attach an additional form. If you do not itemize your expenses, we will process your reimbursement claim based on the documentation received.
- Participants must have all reimbursement claims submitted within 90 days after the date of service.
- Columns **C** and **D** are not needed for Rideshare Transportation reimbursement claims.
- For questions, please call: **844-798-4878**

RECORD OF SERVICE PROVIDED

	(A) Procedure Date *(MM/DD/YYYY)*	**(B)** Procedure Code or Description of Service Rendered *(Service received, Prescription Name, Location traveled to & from)*	**(C)** Diagnostic Code or Description	**(D)** Providers Name *(Last Name, First Initial)*	**(E)** Charged	**(F)** Paid
(1)						
(2)						
(3)						
(4)						
(5)						
(6)						
					Grand Total	

PROVIDER INFORMATION		PAYMENT INFORMATION
Name		Type of Payment *(Check applicable box)* ☐ Check ☐ Debit/Credit ☐ Cash
Address *(Street, City, State, Zip)*		Date of Payment *(MM/DD/YYYY)*
Telephone Number	Tax ID Number	Total Paid

Certification and Release of Information: I, as the undersigned, certify that the information on this Member Reimbursement Claim Form is true and correct to the best of my knowledge. I expressly authorize the release of any medical, health or other personal information necessary to process this reimbursement claim. I certify that I am a participant in the company's Plan corresponding with the member ID and group number identified above and that all expenses for which reimbursement or payment is claimed by submission of this form were incurred during the period while I was covered under the Plan; and that the expenses have not been reimbursed or are not reimbursable under any other coverage. I represent and warrant that I fully understand that I alone am fully responsible for the sufficiency, accuracy, and veracity of all information relating to this reimbursement claim, and that unless an expense for which reimbursement is claimed is a proper expense under the Plan, I may be liable for payment of all amounts (including taxes) which relate to such expense.

Signature of Insured Member _____ Date _____

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Instructions for Filing a Reimbursement Claim

Please read the following instructions about how to report health care services.

Important

1. Your cooperation in completing all items on the reimbursement claim form, signing the back of the form and attaching all required documentation will help us to process your reimbursement claim quickly and accurately.
2. Use this form for all plan reimbursements.
3. You only need to fill out this form if your provider isn't filing the claim for you. Even if the provider is not part of a network (out-of-network), your provider still can file the claim for you.
4. If you received this reimbursement claim form electronically, please make sure all fields are filled out to be able to submit the form. Once done, remember to click on the Submit Fields button on the bottom of page 1 after printing out the completed form.
5. If you are filling the form out by hand, use a new printed form instead of a photocopy. That way we can scan your form and process the reimbursement claim faster. Please print clearly in black ink. Please avoid using a highlighter on any faxes, as documentation becomes illegible.
6. We must get your reimbursement claim within 90 days from the date you received the service, unless your plan or state law allow for more time.
7. Please use a separate reimbursement claim form for each provider, and for each member of your family.
8. To process your reimbursement claim, we need your ID number from the front of your ID card.
9. **Bills must be itemized:** Canceled checks, cash register receipts and non-itemized “balance due” statements cannot be processed.
10. **Each itemized bill must include**: Name and address of provider (doctor, hospital, laboratory, ambulance service, etc.), Name of patient, Date(s) of service, Amount charged for each service, Total Charge, Diagnosis or reason for treatment
11. If the participant has other coverage, and that other insurance is primary, we need an Explanation of Benefits (EOB) for this service from the other insurance company when you send the completed form and itemized bill.
12. When completed, we will review the claim and, if appropriate, send you a check and/or follow-up letter.

In addition, the following information must also be included on bills for the service types listed below:

- **Rideshare Transportation**: Pick-up and delivery points; Number of miles
- **Prescription Drugs**: Duplicate pharmacy generated receipt (not register tape) - must include Rx Number; Date Filled, Medication Name, Form, Strength and Quantity (NOTE: All Prescription Drug charges will be reimbursed to the insured person only)

Send Completed Member Reimbursement Claim Forms To:

Red Rock Management Services, LLC
5130 S Fort Apache # 215-365,
Las Vegas, NV 89148
Email: info@redrockmanagementservices.com
Fax: 702-548-4588
Payer ID: FDMCR