Member Reimbursement Form

Important: Complete a separate Member Reimbursement Form covered services and for each doctor and/or facility. To avoid processing delays, please include the following information with this form:

- Copy of itemized bill showing all services received. Must include name, address, phone number, tax ID number of doctor and/or facility, date of service and all diagnosis and procedure codes.
- Proof of payment for reimbursement requests

Mail all documents to: CCA Health California, Att: Member Reimbursement
18000 Studebaker Rd, Suite 150, Cerritos, CA 90703

Section 1: MEMBER INFORMATION

Last Name:	First Name:	MI:
Member ID Number:	Date of birth (Mo./ Day / Yr.)	Phone Number:
Address:	City:	State: / Zip:

Section 2: OTHER INSURANCE COVERAGE (if applicable)

Other Insurance (OI) Company:	Plan Group:	Phone:
Policy Holder (first, last):	Subscriber ID:	Relationship to OI Policyholder (check one) □ Self □ Spouse □ Dependent
Address:	City:	State: / Zip:

Section 3: SERVICE RECEIVED – If services were Dental Services, please complete Section 4 and for Worldwide Emergency, please complete Section 5.

Name of doctor and/ or facility:	Phone Number of doctor and/or facility:	Fax:
Address of doctor and/or facility:		
Medical description or nature of illness or injury:		
Date of Service:	Amount requested to be reimbursed:	

MEDICAL INFORMATION AUTHORIZATION AND RELEASE

I hereby authorize any physician, health care practitioner, hospital, clinic, or other medically related facility (as listed above) to furnish to CCA Health California, its agents, designees, or representatives any and all information pertaining to medical treatment for purposes of reviewing, investigating or evaluating applications or claims. I also authorize CCA Health California, its agents, designees, or representatives to disclose to a hospital or health care service plan, insurer, or self-insurer any such medical information obtained if such disclosure is necessary to allow the processing of any claim. This authorization shall become effective immediately and shall remain in effect as long as CCA Health California is asked to process claims under my coverage. A photostatic copy of this authorization shall be considered as effective and valid as the original. I hereby certify that the above statements are correct.

Name of person completing form (please print)	Signature:
Date:	Relationship – description of authority to act on behalf of the member, if applicable:

Section 4: DENTAL SERVICES - If you have paid your provider in full for dental services, please complete this form in its entirety.

REQUIRED: Upon receipt of dental services, ask your provider for a statement of billed charges and submit it with this form **OR** have your provider complete the form including signature(s) at the bottom as confirmation of services and payment. **NOTE:** If you have other insurance that is primary to your CCA dental plan, please include the explanation of benefits (EOB) from your other insurance company.

Acceptable statements will include all dental codes for the services rendered on the day of service, including arch, quad, tooth, or surface indicators where applicable. Statements will also include the amount paid by the member. **Missing information may result in delayed reimbursement or denial of coverage.**

PROVIDER INFORMATION			
First Name	Last Name		
NPI #	Tax ID #	Phone #	
Address:	City:	State:	Zip:

OTHER DENTAL COVERAGE (if applicable)			
Other Insurance (OI) Company:	Plan Group:	Phone:	
Policy Holder (first, last):	Subscriber ID:	Relationship to OI Policyholder (check one) □ Self □ Spouse □ Dependent	
Address:	City:	State:	Zip:

DENTAL SERVICES RECEIVED			
DATE OF SERVICE	DESCRIPTION OF SERVICES	SERVICES (Dental Code,)	AMOUNT PAID
		Code:	
		Code:	
		Code:	
		Code:	
		Code:	
		Code:	

I certify that all the submitted information is accurate and reflects all services have been rendered and paid in full.

Member Signature _____ Date _____

Dental Providers Signature _____ Date _____

Section 5: WORLDWIDE URGENT / EMERGENCY – Please complete the questionnaires below if you received health care services while traveling outside of the United States, or on a cruise in foreign or domestic waters.

For worldwide emergency/urgent services, plan will pay the lesser of the provider's billed charges or the national Medicare fee schedule. In order to expedite and qualify for a reimbursement, please obtain the following documents BEFORE you leave the country from which services were received. These items can be difficult to obtain after leaving the country.

1. Copy of all medical records, doctors' notes, doctors' orders, discharge summary, lab reports
2. Copy of itemized statement or any hospital receipts
3. Proof of payment (bank statements, credit card statements)
4. Boarding pass or airline ticket, if applicable

Note: Only covered benefits or those deemed medically necessary will be considered for reimbursement.

What dates were you traveling out of the country?

What was the nature of your emergency resulting in medical treatment?

Were you admitted into the hospital?
- ☐ Yes
- ☐ No

Name of the hospital, clinic or doctor's office where you received treatment?	Date of admission:
Address:	
Country:	Phone:

Did you receive diagnostic tests? ☐ Yes ☐ No	If "Yes", what type?
Were surgical procedures performed? ☐ Yes ☐ No	If "Yes", what type?
Was your primary doctor in the U.S notified? ☐ Yes ☐ No	If "Yes", when?