REIMBURSEMENT REQUEST

(See instructions on reversse side.)

CHRISTUS® Health Plan

US FAMILY HEALTH PLAN
Caring for our Uniformed Services Family

A. SPONSOR/MEMBER INFORMATION

Patient Name: _____

Patient Date of Birth: _____ Patient Member Number: _____

Sponsor Name: _____

B. MEDICAL INFORMATION

Health Care Provider/Company: _____

Date of Service: Amount Paid: _____

C. Diagnosis

What was the illness or injury requiring treatment: _____

_____

If an accident, Indicate date: _____

Were you hospitalized? _____ If yes, hospital name and address:_____

_____

Was this a work-related injury or illness? _____

If yes, please provide the employer's name and address: _____

_____

D. OTHER HEALTH INSURANCE INFORMATION

Do you have other group health insurance coverage? _____

If yes, please provide the following: Certificate Number: Group Number: _____

Subscriber: _____

Insurance Company Name and Address: _____

REQUIRED **Signature:** _____

INSTRUCTIONS

Please print required information, as indicated below. Upon completion return to: CHRISTUS Health, Claims Department, P.O.Box 981696, EL Paso, TX 79990-1696. If necessary verifications are performed without additional research, payment should be received within four to six weeks.

Requests for reimbursements must be received within **one year of the date of service**. Any requests that are submitted after one year will be denied for failure to file in a timely manner.

REIMBURSEMENT OF COPAYS PAID FOR REFERRAL SERVICES *(Consultations, ER, inpatient care, etc., not provided at a CHRISTUS Health facility.)*

1. **Complete Section A**—Patient Member Number is printed on the US Family Health Plan membership ID card.
2. **Complete Section B**—Enter the name of the physician, company, facility, or other health care professional from whom you received and to whom you paid your copay; the date of the service for which you paid; and the amount of copay paid.
3. **Complete Section D**—Enter the name and address of your other health insurance carrier, as well as the subscriber's name, and the certificate and group numbers of your policy. If reimbursement is being requested for multiple services, this information only needs to be filled out once, unless there was a change.
4. **Attach Evidence of Payment**—Attach to this form, copies of:
    a. An EOB or statement indicating payment made from your other health insurance company to the referral provider (physician, hospital, or other) and
    b. A receipt or cancelled check indicating your payment of the copay to the referral provider.

REIMBURSEMENT OF COPAYS PAID FOR PRESCRIPTIONS *(Only use this form when you use your other health insurance prescription drug card and pay your other health insurance cost share. Please note: If your other health insurance does not pay any portion of the claim submitted, you will be reimbursed the price you paid minus your US Family Health Plan copay.)*

1. **Complete Section A**—Patient Member Number is printed on the US Family Health Plan membership ID card.
2. **Complete Section B**—Enter the name of the pharmacy from which you received your prescription and to whom you paid your copay; the date the prescription was filled; and the amount of the cost share paid.

Attach Evidence of Payment—Attach the pharmacy receipts, not cash register receipts, which indicate the date, drug name and strength, the retail price, and the amount of the cost share paid.

REIMBURSEMENT OF OUT-OF-POCKET EXPENSES FOR OUT-OF-AREA SERVICES *(If you received emergency or urgent care, and you were required to pay at the time of service, complete as follows for reimbursement.)*

1. **Complete Section A**—Patient Member Number is printed on the US Family Health Plan membership ID card.
2. **Complete Section B**—Enter the name of the physician, company, facility, or other health care professional from whom you received services; the date of the service; and the amount you paid.
3. **Complete Section C**—Provide as much information as possible. If you need assistance in completing, please call Member Services.
4. **Complete Section D**—Enter the name and address of your other health insurance, if any, as well as the subscriber's name, and the certificate and group numbers of your policy. If reimbursement is being requested for multiple services, this information only needs to be filled out once, unless there was a change.
5. **Attach Evidence of Payment**—Attach a copy of your bill and your receipt or cancelled check.

PLEASE MAKE SURE YOU SIGN THIS REQUEST. WE ARE REQUIRED TO HAVE YOUR SIGNATURE FOR REIMBURSEMENT.