Preferred Care Partners
A UnitedHealthcare Company

Medical Reimbursement Request Form

You can use this form to ask us to pay you back for covered medical care and supplies.

- Check your plan materials to find out what your plan will pay for.
- Fill out a separate form for each member and each provider.
- Include statements from your doctor or provider for each item. These must include a full description of the service or supplies received.
- Include proof of payment (e.g., payment receipt, invoice, or supplier's statement) for each item.
- For foreign travel, fill out one form for each member for the entire trip.
- This form is for medical reimbursement only. There is a separate form for prescription drug reimbursement. Exception: You can use this form for both medical and prescription drugs for foreign travel.
- Send the completed form and documentation to the Medical Claims address on the back of your member ID card. You can find the direction in the Providers section on the back of your card.

Information about the member who received medical services or supplies

Full name _____

Address _____

City _____ State _____ ZIP _____

Phone number (_____) _____ ☐ Male ☐ Female

Date of birth _____

Member ID number _____ Member Group number _____

If you are completing this form for the member, please provide your name, address, and phone number

Full name _____

Address _____

City _____ State _____ ZIP _____

Phone number (_____) _____

What is your relationship to the member?

☐ Spouse or partner ☐ Relative ☐ Attorney ☐ Estate representative ☐ Other _____

Include paperwork showing you have the legal right to act for the member (such as Power of Attorney or Medicare's Appointment of Representative Form). You can find the Appointment of Representative Form on the plan's website, or you can call Customer Service and ask them to send you the form.

Information about other insurance coverage

Please tell us if you have other insurance, such as Travel, Veterans benefits or other employer insurance. Send us a copy of the insurers' Explanation of Benefits that includes the medical care or supplies you are asking us to reimburse. This will help us determine who pays first (primary responsibility) and who pays second (secondary responsibility).

Name of Insurance	Policy Number

Has workers' compensation refused to cover your accident or injury? ☐ Yes ☐ No ☐ NA

If yes, please send us a copy of your Explanation of Benefits or paperwork from a lawyer or workers' compensation saying that it doesn't cover your illness or injury.

Has your auto insurance policy refused to cover your accident or injury? ☐ Yes ☐ No ☐ NA

If yes, please send us a copy of the paperwork from the auto insurance company or a lawyer saying that it doesn't cover your illness or injury.

Check 'NA' (Not Applicable) if you did not submit for coverage.

Where did you get medical care or supplies?

☐ Doctor's office ☐ Urgent care ☐ Emergency room ☐ Home
☐ Assisted living facility or nursing home ☐ Hospital
☐ Other _____

Did you get dialysis outside of the plan's service area? ☐ Yes ☐ No
Check 'No' if you are enrolled in the UnitedHealthcare Senior Supplement plan.

Name of doctor or facility _____

Address _____

City _____ State _____ ZIP _____

Did you get medical care or supplies while traveling?

Type of travel: ☐ Cruise ☐ Foreign country

What city and country were you in when you received medical care or supplies?

_____

Puerto Rico, U.S. Virgin Islands, Guam, the Northern Mariana Islands, Saipan, Tinian, Rota, or American Samoa are U.S. territories, not foreign countries.

Foreign travel only:

- Did you get a discount or refund from the provider? ☐ Yes ☐ No
  If yes, how much? _____
- Did you pay a copay or coinsurance? ☐ Yes ☐ No
  If yes, how much? _____

If you have a UnitedHealthcare Senior Supplement plan you must include a copy of your travel plan or itinerary.

Details about your medical care or supplies

We need information about the medical care and supplies you paid for. You may find this information on your doctor's bill or you can call your doctor's office and ask them for the information. Send us copies of your bills, receipts, or statements.

Use the chart on the next page to tell us what you paid for. Please send us proof of payment, with the date you paid and how you paid (check, credit card, etc.).

Sign here _____ Date _____

When I sign above, I am stating that the information on this form is correct, to the best of my knowledge. I understand that if I put information on this form that I know is not true, I could face fines and prison under federal law.

If I sign for the member, it means I have the legal right under state law to sign. I can show written proof of this right if Medicare asks for it.

Fill out this chart to tell us what you paid for. We've provided a sample to help you complete the chart. Fill out a separate line for each service charge. If you need more room, you can use a separate piece of paper. To make sure we can process your reimbursement, you will need to send us proof of payment, with the date you paid and how you paid (check, credit card, etc.).

*Foreign travel only

Date of service	Diagnosis or illness	Treatment or name of item	Number of items or visits	Billed amount	Currency you were billed in*	Amount you paid	Currency you paid in*
1/15/20XX	Diabetes	Office visit	1	$123.00	Euro	$123.00	Euro

Details about your frames or lenses

- Are you submitting for a routine eyewear reimbursement? ☐ Yes ☐No
- Are you submitting for a cataract benefit? ☐ Yes ☐ No
  If submitting for a cataract benefit, what was the date of the surgery: _____

☐ I have included a separate sheet of paper with additional details and other information I think will be helpful when processing my reimbursement.

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Ready to send the completed form?

Please send the completed form and paperwork to the address on the back of your member ID card.

Before you put it in the mail, make sure you:

- Completed and signed the form.
- Include copies of all the paperwork we asked for, including:
    - Proof of payment with the date and how you paid (check, credit card, etc.)
    - Explanation of Benefits from other insurer
    - Travel plan or itinerary (UnitedHealthcare Senior Supplement only)
    - Power of Attorney or Appointment of Representative form
- Keep a copy of everything you send us.
- Request reimbursement within 1 year from the date of service. We may not be able to process your reimbursement after that time.

We will process your request based on your plan benefits. When completed, we will send you a check or a follow-up letter.

Questions? We're here to help.

Call the toll-free Customer Service number on the back of your member ID card.