Medical Expense Reimbursement Form

MEMBER INFORMATION

MEMBER ID – From ID Card			RELATIONSHIP TO MEMBER ☐ Self ☐ Spouse ☐ Child ☐ Other	
NAME Last	First	MI	BIRTHDATE	GENDER ☐ M ☐ F
STREET ADDRESS	CITY	STATE	ZIP CODE	
COUNTY	HOME PHONE – Including Area Code ( ) -		OTHER PHONE - ( ) -	

OTHER INSURANCE INFORMATION – Note: If another insurance is primary, attach a copy of the Explanation of Benefits (EOB).

DO YOU HAVE OTHER HEALTH INSURANCE COVERAGE? ☐ YES ☐ NO	NAME OF OTHER INSURANCE COMPANY	POLICY NUMBER
OTHER COVERAGE'S POLICYHOLDER'S NAME Last	First MI	RELATIONSHIP TO PATIENT ☐ Self ☐ Spouse ☐ Other
MEDICARE CLAIM NUMBER		

MEDICAL EXPENSES

☐ YES ☐ NO ..... Is condition/injury related to an accident involving another party?

____ /____/_____ ..... If yes, on what date did the injury occur?

Be sure to attach a copy of the itemized receipt from the provider -- if spaces below are not enough, add additional page.

Date of Service (MM/DD/YYYY)	Provider Name and Address	National Provider Identifier Number	Services Rendered (Office Visit, Lab, etc.)	Diagnosis Code	**Charges**
			Total Charges		
			Amount Paid		

SIGNATURE

I certify that the above information is true and correct to the best of my knowledge. I authorize the release of any medical information necessary to process this claim.

SIGNATURE: _____ DATE: _____

SEND TO

Please mail completed forms and attachments to:

FirstCarolinaCare Insurance Company
Claims Processing Center
3310 Fields South Dr.
Champaign, IL 61822

If you have any questions, please call (877) 210-9167.

FirstCarolinaCare INSURANCE COMPANY