Reimbursement Request

☐ **Medical Services** ☐ **Dental** ☐ **Vision** ☐ **Services in United States** ☐ **Medicinal Cannabis**

Instructions: Please complete the application in print legibly letters. If you reimbursement expenses are for more than one dependent covered on your policy, you must use one (1) reimbursement form for each dependent. If your expenses for services provided was made by more than one provider (for example: doctor, hospital, laboratory), you must attach the original and legible payment receipt for each provider who provided services. Keep a copy for your records. Reimbursement forms that do not have the requested information completed may delay the processing of your refund or may be returned to you.

Section 1. Applicant Information

Main Subscriber Name:	Last Name(s):	Contract Number:
Patient Name:	Last Name(s):	Contract Number
Physical Address:		DOB: _____ month / day / year
Employees Group Name:	Employees Group Number:	
Main Telephone Number:	Alternate Telephone:	

Section 2. Coordination of Benefits (Please complete this section if the subscriber has another health plan).

Do the patient have another healthcare plan? ☐ Yes ☐ No	Healthcare Company Name: _____ Contract Number: _____

Section 3. Provider Information

Reimbursement form is related to a: ☐ Car accident ☐ Work accident ☐ Other type of accident ☐ Provider do not accept health plan ☐ FM Cannabis C6 P ☐ Do not apply

Provider name that provided medical services:	Specialty: Telephone: (____)

Office Address:

Date of Service	CPT Code	Service Description	Amount Paid

Section 4. Subscriber Authorization

I certify that the information provided in this application form is correct and complete.

Subscriber Signature or Authorized Representative Date:

First Medical Health Plan, Inc., offers sign language and language interpreter services free of charge. This includes alternate format service such as; Braille, large print and translation into other languages, verbal or written, among others. If you need plan information in another format or language, please contact First Medical Health Plan, Inc,. at the telephone number that appears on the back of your card or visit any of our Service Offices from 8:00 a.m. to 5:00 p.m. First Medical Health Plan, Inc., complies with applicable Federal Civil Rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

For Office Exclusive

Eligibility: ☐ Active ☐ Not active	Date of Reimbursement receipt:	Verified by:
Payment verification processing period:	Amount to refund: $	Authorized by: