



MEMBER REIMBURSEMENT CLAIM FORM

Attach all receipts to the back of this form

Claims without the proper identification numbers and information will not be processed. To avoid undue delay, please complete all required areas of information on this claim form.

PART ONE - Member Information

Member Number: _____ Group Number: _____

Patient's Name: _____

Birth Date: _____ Telephone: (_____) _____
Month Day Year (Area Code) Work # Home #

Patient Is: Male Female Member Spouse Child Other _____
Explain Relationship

PART TWO - Illness/Injury

Describe the illness or injury: _____

PART THREE - Medical Service

A Claim Form must be completed for each provider involved. Approved claims for an Out-of-Plan Provider will be paid directly to the Member. Please refer to instructions on reverse side.

Were services authorized by your Primary Care Physician?
YES NO

Physician: _____

Facility: _____

Please state the reason you paid for these services.

Where were services provided?

City _____ State _____

May we expect additional bills relating to this claim?

YES NO

Continued on reverse side

PART FOUR - Pharmacy

All Pharmacy receipts must include the following 9 items:

- | | |
|------------------------------------|------------------------------|
| 1) Date Prescription Filled | 6) Days Supply |
| 2) Name & Address of Pharmacy | 7) Prescription (Rx) Number |
| 3) NDC (National Drug Code) Number | 8) DAW (Dispense As Written) |
| 4) Name of Drug and Strength | 9) Amount Paid |
| 5) Quantity | 10) Proof of Payment |



Instructions for filing for Member Reimbursement

- Your claim cannot be processed unless this form is complete.
- As a Member of FirstCare, you are responsible to send your request for reimbursement within ninety (90) days from the date on which services were incurred.
- FOR MEDICAL SERVICES: An itemized statement from the provider(s) of service indicating payment was made in full at time such services were rendered.
- FOR PHARMACY: See above-listed requirements.
- A Member will be reimbursed for a covered health service in which he/she is required to make full payment at time of the service. For claims to be considered for reimbursement by FirstCare, they must meet your benefit package criteria. (If a service is obtained which is normally not a covered benefit under your benefit package, it would not be a service eligible for reimbursement.) Refer to your "Evidence of Coverage" (EOC) for details of your benefit package.

I certify that I am the subscriber and that the services and/or prescriptions that are shown on this claim have been received by me or a dependent covered under my Evidence of Coverage.

Subscriber's Signature

Date

Return completed form with attached receipts to:

FirstCare
Attn: Reimbursement
12940 North Highway 183 - Austin, TX 78750

**If you have any questions concerning
this request for reimbursement,
contact the Member Services
Department at:**

1-800-884-4901