22Health
A Division of Community Care Plan

MEMBER MEDICAL CLAIM REIMBURSEMENT REQUEST FORM

Please use this form to be reimbursed for out-of-pocket expenses related to eligible medical services.

1: SUBSCRIBER INFORMATION

Full Name _____

Member ID # _____

Date of Birth _____/_____/_____

Phone # _____

Email Address _____

Street Address _____

City _____ **State** _____ **Zip Code** _____

2: MEMBER INFORMATION

Member Name (If different from subscriber) _____

Relationship to Subscriber ☐ Self ☐ Spouse ☐ Dependent ☐ Other

Date of Service _____/_____/_____

3: PROVIDER INFORMATION

Provider Name/ Facility _____

Provider Phone # _____

NPI or Tax ID (if known) _____

In-network provider ☐ Yes ☐ No ☐ Not Sure

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4: REIMBURSEMENT REQUEST DETAILS

Please attach the following required documentation:

- ☐ Itemized bill, including CPT/HCPCS codes and diagnosis, if available/applicable
- ☐ Proof of payment (e.g. receipt, credit card statement, provider payment confirmation)
- ☐ Explanation of Benefits (EOB), if available
- ☐ Prescription, if available

Total Amount Paid Out of Pocket: $ _____

Reason for reimbursement request:

- ☐ Service not billed by provider
- ☐ Emergency/out-of-network care
- ☐ Other (please explain:)

_____

_____

_____

5: MEMBER CERTIFICATION

I certify that the above information is accurate and complete. I understand that submission of this form does not guarantee reimbursement, and the request will be reviewed according to the terms of the Member Faces health plan and applicable benefit guidelines.

Member Signature _____

Date _____

6: SUBMIT DOCUMENTATION

Please submit this completed form along with the required documentation via email to:

support@22Healthplan.com