FirstCare™
HEALTH PLANS

Member Claim Reimbursement 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: _____

Date of Birth: _____ Telephone: ____ - ____ - _____

Patient Is: Male ☐ Female ☐ Member ☐ Spouse ☐ Child ☐ Other _____

*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 (PCP)?

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 ☐

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*PART FOUR—Pharmacy

All pharmacy receipts must include the following items:

1. Date prescription filled
2. Name and address of pharmacy
3. National Drug Code (NDC) Number
4. Name of drug and dosage
5. Quantity
6. Days supply
7. Prescription (Rx) number
8. Dispense As Written (DAW)
9. Amount paid
10. Proof of payment

INSTRUCTIONS FOR MEMBER REIMBURSEMENT

- Your claim cannot be processed unless this form is complete.
- As a FirstCare Member, you are responsible to send your request for reimbursement within 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 FirstCare 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 shown on this claim have been received by me or a dependent covered under my Evidence of Coverage.

Member's Signature _____ Date _____

Return completed form with attached receipts to:

FirstCare Health Plans
P.O. Box 211342
Eagan, MN 55121

If you have any questions concerning this request for reimbursement, contact FirstCare Customer Service at:

1.800.884.4901