MEDICAL CLAIM FORM
DIRECT MEMBER REIMBURSEMENT REQUEST

INSTRUCTIONS: Make sure you and your physician or other healthcare professional fill out this form completely for you to receive timely reimbursement for paid medical services.

- Type or print the requested information
- Consult your healthcare provider regarding section labeled "Service Information."
- Attach itemized receipts for each supply or service you requested reimbursement for. (Do not staple items.)
- Remember to keep a copy of this claim form and all receipts for your records.
- A separate form must be completed for each provider you are requesting reimbursement for.
- If you have any questions, please contact Member Services at 855-969-5861 (TTY: 711), October 1 - March 31, 8 a.m. to 8 p.m. ET, 7 days a week or April 1 - September 30, 8 a.m. to 8 p.m. ET Monday through Friday.

MEMBER INFORMATION

Last Name	First Name	Middle Initial	Date of Birth / /

Street Address	City	State	Zip Code

Daytime Phone Number	CommuniCare Advantage Member ID

PROVIDER INFORMATION

Name	Tax ID Number	NPI Number

Street Address	City	State	Zip

SERVICE INFORMATION

Date of Service	Location of Service	Codes for Service or Supplies	Diagnosis Codes (ICD10)	Number of Units	Amount Charged
					$
					$
					$
					$
				TOTAL CHARGES	$
				TOTAL YOU PAID	$

UPON COMPLETION MAIL TO:
COMMUNICARE ADVANTAGE
ATTN: CLAIMS
PO BOX 21063
EAGAN, MN 55121

If all information has been correctly submitted within 180 days of service, you can expect your claim to be processed within 60 calendar days of receipt by CommuniCare Advantage. **THIS IS NOT A GUARANTEE OF PAYMENT**. Actual payment for covered services will be paid at the appropriate level according to your plan benefit.