

**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 (866) 212-4582 (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
					\$
					\$
					\$
					\$
UPON COMPLETION MAIL TO: <b>COMMUNICARE ADVANTAGE</b> <b>ATTN: CLAIMS</b> <b>PO BOX 3398</b> <b>Little Rock, AR 72202</b>				<b>TOTAL CHARGES</b>	\$
				<b>TOTAL YOU PAID</b>	\$

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.