



**CLAIM REIMBURSEMENT REQUEST FORM**

**Member Information**

Name:		Member ID#
Address:		
City:	Zip:	Phone:
DOB:		

**I am requesting reimbursement because:**

- I paid for emergency or urgent care services out of my own pocket.
- My provider is sending me a bill I do not think I should pay.
- I purchased medical supplies out of my own pocket.
- I used an out of network pharmacy to get a prescription filled (*Note: Part D drugs you buy outside of the United States and its territories will not be reimbursed.*)
- I paid the full cost for a prescription because:
  - I did not have my card with me
  - I used an out of network pharmacy to get a prescription filled
  - Other reason \_\_\_\_\_

This is the amount I feel I am owed: \$ \_\_\_\_\_

Date of Service: \_\_\_\_/\_\_\_\_/\_\_\_\_

Provider or Pharmacy: \_\_\_\_\_

Brief Explanation: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**I CERTIFY THAT THE ABOVE STATEMENTS ARE CORRECT**

Member Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Any person who knowingly and with intent to defraud any insurance company and files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.



**Please make sure to include your original receipts or bill (keep a copy for your records).**

When we receive your request, we will let you know if we need any additional information from you. Otherwise we will consider your request and decide whether it will be covered and, if it is covered, the amount we will cover.

Submit to:

Aspire Health Plan  
P. O. Box 5490  
Salem, OR 97304

Aspire Health Plan is an HMO and HMO-POS plan sponsor with a Medicare contract.

P.O. BOX 5490, SALEM, OR 97304 ■ (855) 570-1600 / 711 (TTY)

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Enrollment in Aspire Health Plan depends on contract renewal.

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