ASPIREHEALTHPLAN

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 paid for routine vision or routine dental services.
- ☐ 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
  - ☐ Other reason _____
- ☐ Other (describe): _____

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

If you have any questions, please call Aspire Health Plan at (855) 570-1600. TTY users should call 711. We are open 8 a.m.–8 p.m. PT Monday through Friday from April 1 through September 30 and 8 a.m.–8 p.m. PT seven days a week from October 1 through March 31 (except certain holidays).