MediExcel HEALTH PLAN

Healthcare Services Reimbursement Request Form

INSTRUCTIONS

1. Submit your request for reimbursement within 180 days of the date of service. Reimbursement of approved charges will be mailed within 30 days of receipt of complete documentation. Applicable copay/coinsurance will be deducted from the reimbursement payment amount.

2. Only covered benefit services will be considered for reimbursement.

3. The patient requesting reimbursement of healthcare services must sign this form. If the patient is under 18, the form must be signed by the parent and/or guardian enrolled in MediExcel Health Plan.

4. **For healthcare services in Mexico**, please deliver the following documents to Member Services in person:
- This form completed and signed.
- A copy of the "factura." The factura should be made out to "**Medi-Excel, SA de CV with RFC# "MED091108FY4**" and the official address, "**Avenida Paseo de Los Héroes 2507, Zona Río Tijuana, Baja California 22320**."*(Please note: under Mexican law, all businesses, including health care providers, are required to provide the client with a factura for all financial transactions. The factura is the official instrument that is used by all commercial entities in Mexico to report business income to the Mexican equivalent of the IRS).*
- Proof of payment – itemized receipt, front and back of cancelled check, credit card statement, signed statement of cash payment. ***(For prescription drugs: include drug label receipt with name of drug and dosage).***
- Supporting documentation – medical record of visit, copy of doctor's prescription, lab, and/or x-ray order.
- Member Services is located inside Excel Hospital in Tijuana, contact them at (619) 365-4346 or at memberservices@mediexcel.com.

5. **For healthcare services in the U.S.**, please mail or e-mail the following documents to the Claims Department:
- This form completed and signed.
- Statement – itemized billing statement from provider(s).
- Proof of payment – itemized receipt, front and back of canceled check, credit card statement, signed statement of cash payment. ***(For prescription drugs: include drug label receipt with name of drug and dosage).***
- Supporting documentation – medical record of visit, copy of doctor's prescription, lab, and/or x-ray order.
- Mail to MediExcel Health Plan - Attention Claims, 750 Medical Center Court, Ste. 2, Chula Vista, CA 91911
- Email to claims@mediexcel.com

6. Please retain copies of all paperwork submitted with this reimbursement for your records.

PATIENT INFORMATION

Last Name	First Name	Member ID #

Street Address	City	State	Zip Code

Telephone Number or E-mail Address

Were services received as a result of an accident? ☐ Yes ☐ No	Were services received as a result of an injury at work? ☐ Yes ☐ No

PARENT/GUARDIAN – COMPLETE ONLY IF THE PATIENT IS UNDER 18 YEARS OF AGE

Last Name	First Name	Member ID #

PROVIDER INFORMATION

Provider Name	Provide Telephone Number

Provider Address

Briefly Describe Services Rendered for this Reimbursement:

Amount Paid to Provider Above:	How was Payment Made? ☐ Check ☐ Credit Card ☐ Cash *(signed statement required)*

CERTIFICATION STATEMENT – READ, SIGN AND DATE

I certify that the above information is true, the attached material is correct, unaltered, and the expenses were incurred by the patient named above. I understand all documents submitted become the property of MediExcel Health Plan and will not be returned. I understand that if I submit false receipts or fraudulently altered documents, I may be disenrolled from MediExcel Health Plan and/or subject to civil or criminal penalties. **California Residents:** for your protection, California law requires the following to appear on/with this form. Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison. I authorize the release of any information needed to review or process this request.

Patient Signature (*or of Parent/Guardian if Patient is under 18*) _____ Date _____

MediExcel Health Plan Use Only	Date Processed:	Processed By:	Approved By: