Member Request Form for Reimbursement of Healthcare Services

INSTRUCTIONS TO REQUEST REIMBURSEMENT

1. You must submit your request for reimbursement within 180 days of the date of service. Reimbursement for approved charges will be mailed within 30 days of receipt of complete documentation. Applicable copayments and/or co-insurance will be applied to reimbursement amount of payment.
2. Only covered benefit services will be considered for reimbursement.
3. The patient who is requesting the reimbursement of healthcare must sign this form. If the patient is under 18 years old, the form must be signed by the parent or guardian who is enrolled in MediExcel Health Plan.
4. Send this completed form and the following documents to MediExcel Health Plan. Please keep copies for your records.
   - Statement – itemized billing statement from provider(s). If from Mexico, please include a copy of the "factura." ***(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 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.
5. Deliver in person, e-mail or mail the form and required documentation to:

MediExcel Health Plan
Attention: Claims
750 Medical Center Ct., Suite 2
Chula Vista, CA 91911
Tel: (619) 421-1659
E-mail: claims@mediexcel.com

PATIENT INFORMATION

Last Name	First Name	MediExcel Health Plan 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 this section ONLY if the patient is under 18 years of age.

Last Name	First Name	MediExcel Health Plan ID#

PROVIDER INFORMATION

Name of Provider:	Provider Telephone Number:
Provider Complete Address:	
Briefly Describe Services Rendered for this Reimbursement:	
Amount Paid to Above Provider:	How Was Payment Made? ☐ Check ☐ Credit Card ☐ Cash (need signed statement)

CERTIFICATION STATEMENT – Read, Sign and Date

I certify that the above information is true and the attached material is correct and 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 a Child) Date

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