



Member Reimbursement Request Form Medical Services

Purpose

The purpose of this form is to ask for a refund from Sharp Health Plan for the cost of approved medical services

Instructions

1. You must submit your reimbursement request within 180 days of the date of service. Reimbursement for approved charges will be mailed within 30 days of receipt of complete documentation. Cost Share may be applicable.
2. Complete a separate form for each member who is requesting reimbursement. Only one form is needed per member.
3. The member who received the medical services must sign this form. If the member is under 18 years old, the form must be signed by the parent or guardian who is enrolled in Sharp Health Plan.
4. Send this completed form and the following documents to Sharp Health Plan. Keep copies of all items sent to Sharp Health Plan:
 - Statement, e.g., itemized billing statement from provider(s).
 - Proof of payment, e.g., itemized receipt, front and back of canceled check, or credit card statement.
 - Medical records are required for reimbursement requests over \$200.

Submit

Please submit the finished form and required documents by mail, in person, or fax:

**By Mail or In Person:**

Attention: Claims Research
 Sharp Health Plan
 8520 Tech Way, Suite 200
 San Diego, CA 92123

**By Fax:**

Attention: Claims Research
 1-858-636-2276

Member Information (Complete this section for all reimbursement requests.)

First name:	Last name:	Middle initial:
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ID#:	Phone number: 1- - -	Birth date (MM/DD/YY): (/ /)
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Home address (NOTE: Approved reimbursements will be mailed to this address - P.O. box is not allowed.):

City:	State:	ZIP code:
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Please explain the reason you had to seek medical services.

Were services received as a result of an accident? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, give the date of the accident: (/ /)
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Were services received as a result of an injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, give the date of the incident: (/ /)
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Parent/Guardian enrolled in Sharp Health Plan (Complete this section if the member is under 18.)		
First name:	Last name:	Middle initial:
ID#:	Phone number: 1- - -	Birth date (MM/DD/YY): (/ /)
Home address (P.O. box is not allowed):		
City:	State:	ZIP code:
Other Health Coverage (Complete this section if you have other health coverage.)		
Other health plan name:	Health plan phone number: 1- - -	Effective date of other coverage (MM/DD/YY): (/ /)
Policy holder's name:	Policy holder's ID#:	Policy holder's birth date (MM/DD/YY): (/ /)
Type of coverage: <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Other	Type of policy: <input type="checkbox"/> Self only <input type="checkbox"/> Self and spouse <input type="checkbox"/> Family <input type="checkbox"/> Other	
Certification Statement		
I certify that the above information is true and the attached material is correct and unaltered and that the expenses were incurred by the patient named above. I understand all documents submitted become the property of Sharp Health Plan and will not be returned. I understand that if I submit false receipts or fraudulently altered documents, I may be disenrolled from Sharp Health Plan and/or subject to civil or criminal penalties. I authorize the release of any information needed to review or process this request.		
Member's name (Parent/Guardian if child):	Member's signature (Parent/Guardian if child):	Date (MM/DD/YY): (/ /)



If you need assistance, we're here to help.

You can call Customer Care at 1-858-499-8300 or toll-free at 1-800-359-2002, or email us at customer.service@sharp.com.

We are available to assist you Monday through Friday, 8 a.m. to 6 p.m.

IMPORTANT: Can you read this letter? If not, we can have somebody help you read it. You may also be able to get this letter written in your language. For free help, please call Sharp Health Plan right away at 1-858-499-8300 or 1-800-359-2002.

IMPORTANTE: ¿Puede leer esta carta? Si no le es posible, podemos ofrecerle ayuda para que alguien se la lea. Además, usted también puede obtener esta carta en su idioma. Para ayuda gratuita, por favor llame a Sharp Health Plan inmediatamente al 1-858-499-8300 o 1-800-359-2002.