REIMBURSEMENT FORM

You may use this form to submit a request for reimbursement for medical items, services, or Part B drugs that you paid for directly. Please provide a copy of proof of payment and an itemized statement with this request. You must submit your request within 12 months of the date you received the service, item or Part B drug. Applicable copays or coinsurance will be subtracted from reimbursement (when applicable). If we deny your reimbursement, you will receive written notice along with your appeal rights. For reimbursement for Part D drugs, please use the form found at https://mcpartnerstx.com/prescription-drug-coverage/.

Name of Person Submitting Request: _____

☐ **Member**

☐ **Authorized Representative (see the Appointment of Authorized Representative section below)**

CONTACT INFORMATION OF AUTHORIZED REPRESENTATIVE (IF APPLICABLE)			
Address	**City**	**State**	**Zip Code**
Phone Number			

MEMBER INFORMATION			
First Name	**Last Name**	**Member ID Number**	
Address	**City**	**State**	**Zip Code**
Phone Number	**Date of Birth**		

REIMBURSEMENT REQUEST DETAILS
Name of Provider:
Date of Service:
Amount Paid:

APPOINTMENT OF REPRESENTATIVE

If you are submitting a reimbursement request on the member's behalf, you must submit documentation to support your legal status as the member's representative. Examples of legal representatives include a Power of Attorney (POA), legal guardian, healthcare proxy, person designated under a health care consent statute, or an executor of an estate. If you do meet these requirements, you and the member must complete an Appointment of Representative (AOR) form. You can find a copy of the AOR form on the web at https://www.cms.gov/medicare/cms-forms/cms-forms/downloads/cms1696.pdf or you can call our Member Services Department and request that a copy of the form be mailed to you. We cannot act on a request from a representative without the appropriate legal documentation or AOR form.

SUBMISSION

Send this form, proof of payment and itemized statement, and a copy of your representative documentation or AOR form (if applicable):

MedCare Partners Health Plan of Texas
11602 Bellaire Blvd., Suite C
Houston, TX 77072

You may also fax your request to 1-888-200-3558.

For more information, please contact Member Services at 1-866-627-8901 (TTY users can call 711), 7 days a week from 8 am to 8 pm (except Thanksgiving and Christmas Day) from October 1 – March 31 or Monday through Friday from 8 am to 8 pm (except for Federal holidays) April 1 – September 30.