PrimeCare
Part of OptumCare™

Member Reimbursement Claim Form Instructions:

Please use this form to file your Reimbursement Request. You must submit these documents within one year from the date the services were received, unless timely filing was prevented. Please be advised that this process may take up to 60 days to receive a determination of your request. The Member Submitted Claim Form must be completed in full and accompanied by an itemized bill from your provider that includes the following information:

- The name and address of the person or organization providing the service.
- The full name of the patient receiving the service or purchase.
- The date of each service or purchase.
- The description of each service or purchase.
- The charge for each service or purchase.

Services rendered by more than one provider may not be combined on one claim form. A separate claim must be submitted for each provider.

You must attach copies of all receipts if you paid for the services already. If proof of payment is not submitted, payment may be issued to the provider or you.

Send us your Member Claim Form with all bills and supporting documentation.

Please keep photocopies of your bills and supporting documentation for your personal records.

**In order to file a claim on behalf of a member, you must provide a Power of Attorney or an Appointment of Representative*

If you have any questions or concerns regarding this matter, you may call our Customer Services Department 1-800-956-8000 (TTY users: 711). We are available to assist you between the hours of 8:00 – 4:30, Monday – Friday.

This completed form, together with the itemized bill(s) and supporting documentation (including proof of this payment, if applicable) should be submitted to:

PrimeCare
Customer Service
3990 Concours
Suite 500
Ontario, CA 91764
Attn: Member Reimbursements

Fax: (866) 838-9104

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MEMBER REIMBURSEMENT CLAIM FORM

MEMBER	
Name:	HMO Member ID:
Address:	
Phone:	Date of Birth:
Gender: ◉Male ○Female	Other insurance (if any):

PROVIDER INFORMATION	
Provider/Facility Name:	
Address:	
Date(s) of Service:	Expected Amount:
Place of Treatment: ◉Office ○Hospital/ER ○Urgent Care ○Clinic ○Other:	

Any claim filed without the following required documentation will be returned as incomplete:

- Itemized bill from your provider (See back page for necessary information)
- Proof of payment, If cash payment - submit copy of receipt; for all other forms of payment - submit copies of front/back of check, money order or credit card/bank statements.
- Power of Attorney or Appointment of Representative, if filing claim on behalf of a member
- Additional supporting information (referral, prescription, medical records)

CLAIM INFORMATION	
Describe the illness or injury for which you received treatment and reason why you went to this provider (attach a separate page, if needed):	
If injection received, check below: ☐Flu Shot ☐Pneumonia ☐Other:	Additional information: ☐Services received outside the U.S. (Please review plan benefits for coverage guidelines) ☐Other:

SIGNATURE OF MEMBER OR REPRESENTATIVE*	
Print Name:	Relation:
Signature:	Date: