Covered Benefit Reimbursement Form

Fill out this form to request reimbursement for amounts you PAID out-of-pocket.

- Include proof of payment (such as a paid receipt) that includes the name of the covered benefit along with this completed form. If we don't receive the required information, your request will not be processed. Incomplete or unsigned forms will be returned.
- Proof of payment should only include the covered benefit. Avoid submissions that include groceries, household items, etc.
- The covered benefit reimbursement form must be filed no later than 12 months (or 1 full calendar year) after the date when the services were provided. Claim(s) submitted to Excusive Care after these time limits will not be considered for payment.
- Keep a copy of this form and all documents for your records.

Please submit reimbursement form via Mail, Fax, or Email

Exclusive Care Health Plan Po Box: 1508 Riverside, Ca 92502-1508	Fax: (951) 955-0055	Email: epo@rivco.org

Subscriber/Policy Holder Information

Subscribers Name: _____ Member ID: _____

Member Address: _____ Phone #: _____

_____

Information about Member requesting Reimbursement

Name: _____ Member ID: _____

What is your relationship to the subscriber/policy holder?

☐ Self ☐ Spouse/Partner ☐ Qualified Dependent

Do you have other insurance? ☐ No ☐ Yes (Submit a front and back copy of other Insurance Card)

Other Insurance Name: _____ Effective Date:_____

Information about Covered Benefit Reimbursement Request

☐ Breast Pump (Up to a Maximum $225.00) ☐ COVID Testing Facility

☐ Hearing Aids ($3,000 every 36 months) ☐ Vaccines (Flu, Shingles, etc.)

☐ Urgent Care / Emergency Room outside United States (You must have all your medical and billing records professional translated into English before submitting a claim for reimbursement)

☐ Other _____

Date of Purchase/Service: _____ Amount: _____

Medical Provider/Retailer Name: _____

_____ _____

Signature Date

I certify that the information on this form is correct to the best of my knowledge and authorize the release of any medical information necessary to process this claim.