

## CenCal CareConnect (HMO D-SNP) Member Reimbursement Claim Form

This form may be used for CenCal CareConnect.

**Important:** Complete a separate Member Reimbursement Claim Form for each member asking for reimbursement for covered services and for each doctor and/or facility.

To avoid processing delays, please include the following information with this form:

- A copy of the itemized bill showing all services received. The bill must include the doctor's and/or facility's name, address, phone number, tax ID number, and all diagnosis and procedure codes.
- Proof of payment.<sup>1</sup> (Keep a copy of all receipts and documents for your records.)
- If a member's representative completes this form, please fill out an Appointment of Representative (AOR) Form and attach it to the submission.

**Mail all medical claims to:**

CenCal CareConnect Attn: Claims  
4050 Calle Real  
Santa Barbara, CA 93110

**Any missing information may cause a delay in processing your request.**

If you have questions, call our Member Services department at **1-877-814-1861** (TTY: CA Relay at **711**), 7 days a week, 8 a.m. to 8 p.m. PT.

### SECTION 1: MEMBER INFORMATION.

**PLEASE COMPLETE A SEPARATE FORM FOR EACH PERSON WHO RECEIVED SERVICES:**

First Name:  Last Name:  Middle Initial:

Member ID #:  Date of Birth:

Home Phone Number:  Email Address:

Address:

City:  State:  ZIP code:

### SECTION 2: OTHER INSURANCE. COMPLETE IF APPLICABLE.

Is the member also covered by other medical insurance at this time?  Yes (Complete the information below.)  No

Name of insurance company:

Policy #:  Member ID#:

Does this member have Medicare coverage?  Yes  No

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### SECTION 3: SERVICES RECEIVED. IF SERVICES WERE RECEIVED OUTSIDE THE U.S., PLEASE ALSO COMPLETE SECTION 4.

Name of doctor and/or facility:

Phone Number of doctor and/or facility:

Address of doctor and/or facility:

City:  State:  ZIP code:

Date of service:  Amount requested to be reimbursed:

Medical description or nature of illness or injury:

### MEDICAL INFORMATION AUTHORIZATION AND RELEASE

I hereby authorize any physician, health care practitioner, hospital, clinic, or other medically related facility (as listed above) to furnish to CenCal CareConnect, its agents, designees, or representatives any and all information pertaining to medical treatment for purposes of reviewing, investigating, or evaluating applications or claims. I also authorize CenCal CareConnect, its agents, designees, or representatives to disclose to a hospital or health care service plan, insurer, or self-insurer any such medical information obtained if such disclosure is necessary to allow the processing of any claim. This authorization shall become effective immediately and shall remain in effect as long as CenCal CareConnect is asked to process claims under my coverage. A photostatic copy of this authorization shall be considered as effective and valid as the original. I hereby certify that the above statements are correct.

Name of person completing form (please print):

Signature

Date

Relationship (description of authority to act on behalf of the member, if applicable):

### SECTION 4: FOREIGN CLAIMS QUESTIONNAIRE

You'll need to complete this section if you received health care services while traveling outside of the United States, or on a cruise in foreign or domestic waters. Be sure to answer every question so your claim can be processed quickly. Please provide all available documents for services received.

What dates were you traveling out of the country?

What was the nature of your emergency resulting in medical treatment?

**SECTION 4: FOREIGN CLAIMS QUESTIONNAIRE (CONT.)**

How long were you ill before you received medical attention?

[Redacted]

Were you admitted to the hospital?  Yes  No

If treated as an outpatient, how many times did you see the doctor? [Redacted]

Name of the hospital, clinic, or doctor's office where you received treatment:

[Redacted]

Date(s) of Admission: [Redacted]

Address: [Redacted]

City: [Redacted] State: [Redacted] ZIP code: [Redacted]

Country: [Redacted] Phone Number: [Redacted]

Name of treating physician: [Redacted]

Phone Number: [Redacted]

Did you receive diagnostic tests?  Yes  No

If "Yes," what type? [Redacted]

Were surgical procedures performed?  Yes  No

If "Yes," what type? [Redacted]

Was your primary doctor in the U.S. notified?  Yes  No

If "Yes," when? [Redacted]

**Note:** Only covered benefits or those deemed medically necessary will be considered for reimbursement.

<sup>1</sup>"Proof of Payment" includes but is not limited to a copy of the credit card charge slip, a cruise ship statement, canceled checks, a bank account statement, cash withdrawal slips, or anything else that shows dates that match the medical service date. A valid receipt or doctor's statement is also acceptable if it shows the amount the member paid.