SHARP HEALTH PLAN

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.
4. Send this completed form and the following documents to Sharp Health Plan. Keep copies of all items sent to Sharp Health Plan:
   - Ask your provider to give you a Superbill or Invoice that includes all of the following for each date of service. IMPORTANT: This information must be on the Superbill as it is required to process the claim. Missing information can result in a delay or non-payment of the claim. Please be sure the information is clear and readable.
     - Patient Name
     - Diagnosis codes
     - Procedure Codes (CPT, HCPC) - with any applicable modifiers
     - Units for each procedure code
     - The billed amount for each procedure code
     - Place of service code
   - Proof of payment in the form of copies of: an itemized receipt, the front and back of a canceled check, or a credit card statement.
   - Medical records are required for reimbursement for all services except emergency room or urgent care services.

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

*Pending safety guidelines

Member Information (Complete this section for all reimbursement requests.)		
First name:	Last name:	Middle initial:
ID#:	Phone number: ( )	Birth date (MM/DD/YY): / /
Home address (NOTE: Approved reimbursements will be mailed to this address - P.O. box is not allowed.):		
City:	State:	ZIP code:
Please explain the reason you had to seek medical services.		

Were services received as a result of an accident? ☐ Yes ☐ No	If yes, give the date of the accident:
Were services received as a result of an injury at work? ☐ Yes ☐ No	If yes, give the date of the incident:

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: ( )	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: ( )	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: ☐ Medical ☐ Dental ☐ Vision ☐ Other	Type of policy: ☐ Self only ☐ Self and spouse ☐ Family ☐ 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.