SHARP HEALTH PLAN
make life better.

Member Reimbursement Request Form - Medical Services

INSTRUCTIONS FOR REIMBURSEMENT REQUEST

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. Copayments will apply.
2. Complete a separate form for each member who is requesting reimbursement. Only one form is needed per member.
3. The patient who received care must sign this form. If the patient is under 18 years old, the form must be signed by the parent or guardian who is enrolled in Sharp Health Plan.
4. Send this completed form and the following documents to Sharp Health Plan. Keep copies of all items sent to Sharp Health Plan.
   - Statement - Itemized billing statement from provider(s)
   - Proof of payment - Itemized receipt, front and back of cancelled check, or credit card statement
   - Medical records - Required for reimbursement requests over $200
5. Fax or mail the form and required documents to:

Sharp Health Plan
Attn: Customer Care
8520 Tech Way, Ste. 200
San Diego, CA 92123-1450
Tel 1(800) 359-2002
Fax (619) 740-8571

PATIENT INFORMATION - Complete this section for all reimbursement requests.

LAST NAME		FIRST NAME	
STREET ADDRESS			CITY
STATE	ZIP CODE	PHONE NUMBER	
DATE OF BIRTH		SHARP HEALTH PLAN ID #	
WERE SERVICES RECEIVED AS A RESULT OF AN ACCIDENT? ☐ YES ☐ NO		IF YES, GIVE DATE OF ACCIDENT	
WERE SERVICES RECEIVED AS A RESULT OF AN INJURY AT WORK? ☐ YES ☐ NO		IF YES, GIVE DATE OF INCIDENT	

PARENT/GUARDIAN ENROLLED IN SHARP HEALTH PLAN - Complete this section if the patient is under 18 years old.

LAST NAME		FIRST NAME	
STREET ADDRESS			CITY
STATE	ZIP CODE	PHONE NUMBER	
DATE OF BIRTH		SHARP HEALTH PLAN MEMBER ID #	

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		POLICYHOLDER'S MEMBER ID #	
POLICYHOLDER'S NAME			POLICYHOLDER'S DATE OF BIRTH
TYPE OF COVERAGE ☐ MEDICAL ☐ DENTAL ☐ VISION ☐ OTHER		TYPE OF POLICY ☐ SELF ONLY ☐ SELF&SPOUSE ☐ FAMILY ☐ OTHER	

CERTIFICATION STATEMENT - Read, sign and date.

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.

PATIENT'S SIGNATURE (PARENT/GUARDIAN IF CHILD) _____ DATE _____

SHARP HEALTH PLAN USE ONLY	CSR NO.

(07/10)