



Community Health Choice (HMO D-SNP)
Member Reimbursement Form

To make sure you are giving us all the information we need to make a decision, please fill out our claims form to make your request for payment. You don't have to use the form, but it will help us process the information faster.

If you have questions about this form, please call Member Service at 1-833-276-8306 toll-free or local 1-713-295-5007, (TTY: 711) from October 1 to March 31, 8:00 am to 8:00 pm, 7 days a week and April 1 through September 30, Monday through Friday, 8:00 am to 8:00 pm CST.

Mail only original clear itemized bill(s) on your provider's letterhead for each medical expense.

You must submit your Part C (medical) claim to us within 12 months of the date you received the service, item, or Part B drug.

Member ID			
The member ID can be found on your Community Health Choice (HMO D-SNP) ID card.			
Member ID			
Member Information			
Last Name		First Name	
Street Address			
City		State	ZIP code
Date of Birth	Sex	Date of injury/illness	Was this related to an auto accident?
	<input type="checkbox"/> M <input type="checkbox"/> F		Yes <input type="checkbox"/> No <input type="checkbox"/>
Was this related to an injury?		Other health insurance?	
Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>	
Name of other health insurance		Policy number	
Member's Signature		Date	Phone
Your right to confidentiality: We will not release any information about you unless you request it in writing or when release is necessary to process or review a claim (to another insurance company, for example). We will tell you which information we release to whom, upon your request.			