Clever Care HEALTH PLAN

Member Reimbursement Medical Claim Form

Complete this form with the help of your health care provider. Collect proof of services and proof of payment. Refer to the FAQ section for help completing this form or call us at **(833) 388-8168 (TTY:711)** 8 a.m. to 8 p.m., seven days a week, from October 1 through March 31, and 8 a.m. to 8 p.m., weekdays, from April 1 through September 30. **Submit the completed and signed form, proof of services, and proof of payment for the services to:** Clever Care Health Plan | Attn: Member Reimbursement Department | 7711 Center Ave, Suite 100 | Huntington Beach CA 92647.

Patient Information

Clever Care Member ID#:*	Last Name:*	First Name:*	Middle Initial:
Date of Birth (MM/DD/YYYY):*	Mailing Address:*		
Telephone Number:*	Patient Email Address:		

Other Insurance Company Name:	Other Insurance Phone Number:	Other Insurance Policy Number:

Claim Information

Healthcare Provider's Name:*	Treatment Setting:*	Telephone Number:	Provider Federal Tax ID #:

Healthcare Provider's Address:*	Were services received outside of the U.S.?* ☐ Yes ☐ No

Detailed explanation of illness/injury, including date(s) of injury/illness:*

Diagnosis Codes	Diagnosis Description	Service Date(s) (MM/DD/YYYY)*	Procedure Codes (for each service)	Procedure Descriptions	Amount Paid*
					$
					$
					$
				Total Amount Paid:	**$**

Member signature is required: I attest that the above information is true and accurate and that the services were received and paid for in the amount requested as indicated above. I understand Clever Care Health Plan may request any additional information it deems necessary to verify that services were received, and payment was made.

Print Name*	Signature*	Date*

*Please fill out the areas marked with asterisk to expedite processing of your request.

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Frequently Asked Questions

Question	Answer
What is this form used for?	This form is used to ask for payment for eligible care you have already received. This form should not be used for Part D Pharmacy services.
What is my responsibility?	Copayments, deductibles, coinsurance, and non-covered services will be patient responsibility.
What if my service was completed out of the service area?	If you were temporarily out of the service area and had a medical or behavioral health emergency, report your emergency to us within one (1) business day. Depending on your plan type, copayments may apply for emergency care received in an emergency room. Routine or maintenance care is not covered outside the service area and will not be reimbursed unless pre-arranged with Clever Care prior to receiving services.
What happens next?	After processing your claims, you will receive an Explanations of Benefits (EOB). The EOB explains the charges applied to your deductible (the fixed dollar amount you pay for covered services before the insurer starts to make payments) and any charges you may owe the provider. Please keep your EOB on file in case you need it in the future. You may also visit CleverCareHealthPlan.com.

Form Field Name	Description
Clever Care Member ID#	ID# with suffix found on the front of Clever Care Health Plan Member ID card.
Provider's Name, Address, Telephone Number, Provider Federal Tax ID #:	A provider includes, but is not limited to, hospitals, physicians, optometrists, psychiatrists, licensed clinical social workers, durable medical equipment suppliers.
In what setting did the patient receive treatment?	Such as office, emergency room, outpatient hospital (for X-rays, tests), inpatient hospital, clinic, medical supply store.
If services were provided outside of the U.S.	If applicable, indicate in what country services were provided, in what language (if not English) the bill and proof of payment, and in what currency the bill was paid.
Diagnosis: What was the patient seen for?	Provide a diagnosis code and detailed description of illness or injury. (e.g., flu, broken leg, manic-depressive disorder, asthma).
Procedures, Services, or Supplies Provided	Provide a procedure code and detailed description (e.g., x-ray, office visit, lab work, leg cast, etc.).
Total Amount Paid	Total amount for which you are requesting reimbursement.
Proof of Service(s)	A document that demonstrates the service was provided, listing date(s) of service, service(s) provided, and dollar amounts paid like a receipt or payment record or medical record.
Proof of Payment	A document that demonstrates payment made by the member was received by the provider of service. Examples: The front and back of the cancelled check written to the provider; a credit card statement or receipt; a statement from the provider indicating payment was made.