



Member Reimbursement Medical Form

This form is to be used for reimbursement of covered services provided in accordance with your Clear Spring Health Plan benefits. Please print clearly. For reimbursement of prescription drugs, please complete a Member Reimbursement Drug Claim Form.

MEMBER INFORMATION		
Last Name:	First Name:	MI:
Member ID:	Date of Birth (MM/DD/YYYY):	
Address (Street, City, State, Zip):		
Phone Number:	Best Time to Reach:	
REASON FOR REQUEST (check all that apply)		
<input type="checkbox"/> Out of area/urgent/emergency request	<input type="checkbox"/> Enrollment/Eligibility Issue	
<input type="checkbox"/> Other, please describe:		
CLAIM DETAILS		
Name of Provider:	Address where services were rendered:	
Date(s) of Service (mm/dd/yyyy):	Billed Amount:	
Describe the items or services that you were seen for ¹ : (e.g. asthma, lab work, ER visit, flu shot, etc.)		
<small>¹ Clear Spring Health requires prior authorization for certain services, devices and equipment as a condition of payment. Refer to your Evidence of Coverage for plan guidelines.</small>		
Amount of reimbursement you are requesting: \$ _____		
Note: Any reimbursement made will be less applicable cost-sharing. Refer to your Evidence of Coverage for details.		
SIGNATURE IS REQUIRED		
<i>I certify that all information provided on this form is correct and that I personally received these services and request reimbursement according to my plan benefits. I understand that fraudulent acts (including false claims) may be subject to civil or criminal penalties. I also authorize release of eligible information pertaining to this claim(s) to the plan administrator, underwriter, plan sponsor, policyholder and/or employer.</i>		
Signature:	Date:	

Clear Spring Health has a contract with Medicare to offer HMO and PPO plans. Enrollment in Clear Spring Health depends on contract renewal.



Please fax or mail the signed and completed form along with proof of payment AND itemized receipt/bill to:

- **Mail:**

Clear Spring Health, Attn: Claims
3601 SW 160th Avenue, Suite 450
Miramar, FL 33027

- **Fax:** 1-866-235-5181

You must submit your claim to us within 365 days of the date you received the service and/or item.

For further assistance, please contact Member Services at (877) 384-1241. TTY users should call 711. We are open 8:00 am to 8:00 pm Monday – Friday from April 1 – September 30 and 8:00 am to 8:00 pm Monday – Sunday from October 1 – March 31.

Clear Spring Health complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al (877) 384-1241 (TTY: 711).

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