Member Reimbursement Medical Claim 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)

☐ Out of area/urgent/emergency request ☐ Enrollment/Eligibility Issue

☐ 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.)

[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*

Amount of reimbursement you are requesting: $_____

Note: Any reimbursement made will be less applicable cost-sharing. Refer to your Evidence of Coverage for details.

Member Reimbursement Medical Claim Form

SIGNATURE IS REQUIRED	
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.	
Signature:	Date:

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
  Po Box 491
  Parkridge, IL 60068

- **Fax:** 1-312-284-1886

- **Email**: claims2@clearspringhealthcare.com

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) 364-4566. 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 (you may leave a voicemail on Saturday, Sunday and Federal Holidays).

Clear Spring Health has a contract with Medicare to offer PPO, HMO, and PDP Plans. Eon Health has a contract with the Georgia Medicaid program and a contract with the South Carolina Medicaid program. Enrollment in these plans depends on contract renewal.

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al (877) 364-4566 (TTY: 711).