COMMUNITY HEALTH CHOICE

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. On certain holidays your call will be handled by our automated phone system.

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 ☐ M ☐ F	Date of injury/illness	Was this related to an auto accident? Yes ☐ No ☐
Was this related to an injury? Yes ☐ No ☐	Other health insurance? Yes ☐ No ☐		
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.			