Member Reimbursement Request Form

(Medical Claim Form for Reimbursement. Not to be used for pharmacy reimbursement.)

If you got a bill that you have not paid, do not complete this form. Call us as soon as possible at (800) 863-4155 for help. TTY users can call the California Relay Service at (800) 735-2929 or call 711.

Section 1. Member Information (person who got the services)

First name	Last name			M.I.
Street address (please include apt. no.)	City	State	Zip code	
Phone no.	Best time of day to reach you			
PHC ID Card no.	Date of birth (MM/DD/YYYY)			

Section 2. If we (PHC) have questions about this form, who can we speak to? If it is someone other than the member or parent of a minor, we will send you an authorization form to complete.

First name	Last name
Phone no.	Best time of day to reach you
Relation to Member: ☐ Self ☐ Spouse ☐ Son ☐ Daughter ☐ Other _______________	

Section 3. If approved, who should the check be made out to? Where do you want it mailed? (Payment is not guaranteed)

First name	Last name		
Street address (please include apt. no.):	City	State	Zip code

Section 4. Tell us the reason why these services were paid for?

I certify that, to the best of my knowledge, the information on this **Form** is true and correct.

Signature	Printed name	Date (MM/DD/YYYY)

Completing this form does not guarantee reimbursement or payment.

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PARTNERSHIP HEALTHPLAN of CALIFORNIA
A Public Agency

How to use this form

This form is **only** to be used if you have paid for Medi-Cal covered services. This form is not to be used for pharmacy reimbursement.

Use a separate claim form for each member who got services.
Include all required documents:

1. Itemize bill (bill that lists all the services given)
2. Proof of payment
3. Medical notes for out-of-state services (notes taken by doctor who gave the services)

You must fill out all sections of this form and **include all the required documents listed above**. If we need more information, we will call you.

Section 1. Member Information
This section is for the member who got the services.

Section 2. Who do we talk to if we have questions?
This section is asking who we should talk to if we have questions. If it is someone other than the member or parent of a minor child, we will need that person to complete the Authorized Representative form.

Section 3. If approved, who should the check be made out to?
This section is asking for information on who the check should be made out to and where to mail.

Section 4. Tell us the reason why you or someone else paid for the services?
This section is to let us know why someone had to pay for these services.

Fax or mail this completed form and required documents to PHC.

Lake, Marin, Mendocino, Napa, Solano, Sonoma, or Yolo county members:

- Fax to: (707) 863-4415
- Mail to: Partnership HealthPlan of California, Attention EUnit, 4665 Business Center Drive, Fairfield CA 94534

Del Norte, Humboldt, Lassen, Modoc, Shasta, Siskiyou, and Trinity county members:

- Fax to: (530) 223-2508
- Mail to: Partnership HealthPlan of California, Attention EUnit 3688 Avtech Parkway, Redding CA 96002

We will send you a letter telling you our decision within 30 days of your request.

If you have questions or need any help, please call us at (800) 863-4155. We are here to help you Monday – Friday from 8 a.m. – 5 p.m. TTY users can call the California Relay Service at (800) 735-2929 or call 711.