Direct Member Reimbursement Form

INSTRUCTIONS: You will need your physician or other healthcare provider to assist and supply information in completing this form, including the procedure code(s) and diagnosis codes(s), if available.

- Attach medical records and proof of payment (ex: payment receipts or a copy of both the front and back of a cashed check) for each supply or service requested for reimbursement. Any missing information may result in a processing delay or denial of the request.
- A separate form must be completed for each individual requesting reimbursement.
- Retain a copy of this reimbursement form and all receipts for your records.

Member Information

LAST NAME	FIRST NAME	MI
MEMBER ID #	BIRTHDATE (MM/DD/YYYY)	PHONE NUMBER
MAILING ADDRESS	CITY	STATE / ZIP

Provider Information

NOTE: This section must be completed. Please contact your health care provider for assistance.

LAST NAME	FIRST NAME
TAX ID #	
STREET ADDRESS	CITY / STATE / ZIP

Service Information

Detail Description for Medical Reimbursement:

_____

_____

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Date of Service	Service Location	Procedure Codes	Number of Units	Diagnosis Codes	Amount Paid
					$
					$
					$
					$
				Total Amount Paid	$

The time limit to submit a request for review is one year from the date of service, this and other important information may be found in Chapter 7 of your explanation of coverage handbook. Please allow us 60 calendar days to complete the processing of your request. Services that were rendered outside of the United States may take longer. **THIS IS NOT A GUARANTEE OF PAYMENT.** Actual payment for covered services will be paid at the appropriate level according to your plan benefit.

Mail or fax this completed form, & all documents to: SECUR Health Plan, 12470 Telecom Drive, Suite 301, Temple Terrace, FL 33637. Fax is 352.616.0909