How To File A Medical Claim Reimbursement Form

- **For Prescription Drug Reimbursements:** DO NOT USE THIS FORM.
  - **Commercial Members:** Complete the RX Reimbursement Form or call the CCHP Pharmacy Unit for help 1-877-661-6230 (Option 3) (TTY 711).
  - **Medi-Cal Members:** If you have paid for outpatient prescription drugs covered by Medi-Cal Rx, DO NOT USE THIS FORM. Please contact the Medi-Cal Rx Customer Service Center at 1-800-977-2273 (TTY 711).
- **Only use this form if you already paid the provider.**
- **If you need help or have questions, call CCHP Member Services at 1-877-661-6230, Option 2 (TTY 711), Monday – Friday, 8am – 5pm.**

Steps:

1) Fill out the Medical Claim Reimbursement Form.
2) Include original receipts, proof of payment, bills, and invoices. Include medical records upon request.
   - An itemized bill(s) or invoice(s) from provider should include:
     - Name of patient
     - Date(s) of service
     - Nature of illness or injury, including medical and hospital billing code(s).
   - Receipt(s) should include:
     - Name of patient
     - Name of doctor, hospital, or other provider
     - Date paid
     - Amount paid
   - Proof of payment
     - A copy of a cashed check or credit card receipt or statement

   Note: In the event of a foreign receipt, payment will be calculated based on dollar conversion rate at the time of service.
3) Submit the completed Medical Claim Reimbursement Form with copies of the bill(s) or invoice(s), receipt(s), proof of payment, and upon request, medical records, to CCHP. You can mail or drop off the documents in person to:

   Contra Costa Health Plan
   Member Services
   595 Center Ave Suite 100
   Martinez, CA 94553

   OR you can email Member.Services@cchealth.org. (However, please note: Your email is not secure. Email at your own discretion.)

Upon approval of your request, a check will be mailed to you within forty-five (45) working days of the receipt of your request.

CONTRA COSTA HEALTH

If you have questions or need help, call
CCHP Member Services
1-877-661-6230, Option 2 (TTY 711)

Member Reimbursement Form

SECTION A: Member information (person who received services)

Last Name **First Name** **Middle Initial**

Home Address **City** **State** **Zip Code**

Mailing Address ☐ Check if same as home address **City** **State** **Zip Code**

_______ / _______ / ____________
Date of Birth (month / day / year)

____
CCHP ID Number

SECTION B: Required information for reimbursement

To prevent processing delays, you MUST provide the following information:

1. **Provider's Bill**: A copy of the provider's bill or invoice issued.
2. **Receipt:** A copy of the receipt showing the amount you paid.
3. **Proof of Payment**: A copy of the cashed check or credit card receipt.

Date(s) of service	
Name of provider (doctor, hospital, ambulance service, pharmacy, lab, etc.)	
Address where service was provided (hospital address, doctor address, etc.)	
Services provided to you (e.g., X-ray, office visit, injection, prescription, etc.)	
Amount billed	
Amount paid	

Note: All documents and information submitted must be legible or the form will be returned.

SECTION C: Explanation of treatment (optional)

Describe the services you received. If you had services with a provider that is not a Contra Costa Health Plan (CCHP) provider, please explain why.

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Was the patient admitted to the hospital?

☐ **No** ☐ **Yes** ➔ If yes, please submit medical records. Tell us the dates below.

Admit Date (month/day/year): _____ /______ / ________

Discharge date (month / day / year): _____ /______ / ________

Note: All documents and information submitted must be legible or the form will be returned.

SECTION D: Member Signature

☐ I am the member or authorized representative (parent / legal guardian if the patient is a minor or legal dependent).

☐ I certify that the information provided on this form is correct to the best of my knowledge.

☐ I authorize the release of all information related to the health care services that was received on the dates of service listed on this form. I understand that this information is necessary to allow Contra Costa Health Plan, to process my claim for payment.

____

Print Name

______________________________________ ______________________

Signature **Date Signed** (month/day/year)

(_________)________________________ ______________________________

Best Contact Phone Number **Best Day(s) of the Week and Times to Call**

Submit completed form and documents via mail, in person, or email

Contra Costa Health Plan
Member Services
595 Center Ave, Suite 100
Martinez, CA 94553

Member.Services@cchealth.org
(Note: Email is not secure method. Email at your discretion.)