MEMBER REIMBURSEMENT FORM

Please provide the following information in order to reimburse appropriately.

Please provide the following information of parent or guardian who paid for services.

Legal name of person who paid for services____

Payment Mailing Address____

Telephone Number where you may be reached_____________________________________

Please provide the following information of Member (Patient) who received medical services.

Legal Name of Member (Patient)____

Date of Birth ____/____/____ Policy Number __________________________ Group Number ____________

Please provide the following information of Supplier (Physician or Facility) who rendered services.

Physician or Facility Name ____

Address ____

Telephone Number (____)_____-________ Tax Identification Number (if available)___________________

Please provide the following information of services.

Date(s) of Service____

Number of Units received___________________ Place of Service________________________________

Diagnosis Code(s) or Description (if available)____

Procedure/HCPC Codes(s) or Description (if available)______________________________________

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Amount Paid and how payment was rendered (Circle one **Cash; Check; Credit Card**)$______________

Please attach: Proof of payment (invoice, statement, paid receipt, cancelled check, credit card statement). If Community Health Plan is secondary, please provide primary explanation of benefits.

Return Form To:
Community Health Plan
Attention: Customer Service Department
137 N Belt Hwy; St Joseph, MO 64506
800-990-9247; Fax 816-271-1266