Member Reimbursement Request Form
Claim Form

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 number	Best time of day to reach you		
Partnership ID card number	Date of birth (MM/DD/YYYY)		

Section 2. Who can we speak to if we have questions?

First name	Last name
Phone number	Best time of day to reach you
Relation to Member: ☐ Self ☐ Spouse ☐ Son ☐ Daughter ☐ Other _____	

Section 3. 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. How much money do you want Partnership to pay you back? $ _____

Section 5. Tell us the reason why you paid for these services

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.

Member Reimbursement Request Form
Claim Form

How to Use This Form

Use this form if you were a Partnership member at the time you got services. Use a separate form for each member and **include all required documents listed below**.

Pharmacy Services (prescription drugs):

- Dates of service on or after January 1, 2022, do not complete this form; call Medi-Cal Rx at **(800) 977-2273** for help.
- Dates of service before January 1, 2022, please complete this form and send the following to Partnership:
    1. Pharmacy receipt (given to you with the medication warning, not the receipt from the cash register)
    2. Proof of payment

All other services:

1. Itemized bill (bill that lists all the services given)
2. Proof of payment
3. Medical notes are required for services received out of the state of California or when requested

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 it.

Section 4. Tell us the amount you want Partnership to pay you back.

Section 5. 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 the required documents to Partnership.

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

We will call you or 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**.