Medical Reimbursement (DMR) Form

INSURED INFORMATION – ALL SECTIONS MUST BE COMPLETED		
Insured's Name (as shown on the ID card) First M.I. Last	ProCare Advtanage Identification Number (as shown on ID Card)	
Insured's Street Address ☐ (Check if new address)	Patient's Date of Birth Month Day Year	Patient's Sex ☐ Male ☐ Female
City State Zip Code	Daytime Phone Number (in case additional information is needed) ( )	

	For Office Use Only	
		CUSTOMER CLAIM FORM

Please see the other side of this form for instructions and mailing information. Please print or type all information.

PATIENT'S CONDITION AND TREATMENT		
Treatment was for ☐ Illness ☐ Injury	Condition was due to	If injury, give date Month Day Year
What is the patient being treated for?	First date care was received for the illness or injury Month Day Year	

ATTACHMENTS
Please check the types of documents you have attached copies of ☐ Itemized bill(s) for this patient

AUTHORIZATION
I certify that the information on this form is complete and correct to the best of my knowledge. I authorize the release of any medical information necessary to process this claim. Signature of Insured _____ Date _____

SEE INSTRUCTIONS ON OTHER SIDE BEFORE MAILING

INSTRUCTIONS FOR FILING A CLAIM

This form is designed to help you file a claim for health care services received by you. If a doctor, hospital, or other health care provider has already filed a claim directly with ProCare Advantage on your behalf, please do not send a Customer Claim Form for the same services.

STEP 1. Complete the Insured Information section.

- Please print or type.
- All sections must be completed for processing. Make sure to write in your Identification Number as shown on your ID card including any letters in front of your number.
- Please provide a daytime telephone number where you can be reached if more information is needed to process this claim.

STEP 2. Complete the Patient's Condition (diagnosis) and Treatment section

STEP 3. Review the bills for health care services that you will be sending, and please keep a copy as bills cannot be returned.

Bills must show an itemized charge for each service the patient received. Each bill must show:

- The patient's name.
- The name, address, and tax identification number of the health care provider.
- The date of each service, the charge for each service, and a description of each service.
- The Referral Number for specialist care if your program requires referrals from your Primary Care Physician.

STEP 4. Complete the Attachments section. If these same services were covered first by another health care plan (the patient's primary plan), make sure you have copies of the other plan's statements showing how each service was paid.

STEP 5. Sign the Authorization.

STEP 6. MAIL YOUR COMPLETED CLAIM TO:

ProCare Advantage
PO Box 5849
Glen Allen, VA 23058-5849