



Member Request for Reimbursement Form

Please use one (1) form for each health expense you are asking Alameda Alliance for Health (Alliance) to reimburse to you.

INSTRUCTIONS

1. Please print clearly or type in all of the fields below.
2. Include the required attachments. The Alliance cannot accept requests that are missing the required documents.
 - **What to Submit:** Complete this form and provide a copy of the original bill(s). You must attach detailed bills, which you can request from your provider, and proof of payment (such as a receipt). Please also submit in writing why you had to pay for services.
 - **When to Submit:** We will accept and review requests received within one (1) year after the date the bill is paid. We cannot accept paid bills received more than one (1) year after the bill was paid.
3. Mail this completed form with the required documents to:

Attn: Grievance & Appeals Department
Alameda Alliance for Health
PO Box 2818
Alameda, CA 94501-0818

If you have questions, please call:

Alameda Alliance Wellness Member Services Department
Monday – Sunday (seven (7) days a week), 8 am – 8 pm
Toll-Free: **1.888.88A.DSNP (1.888.882.3767)**
If you cannot hear or speak well, use TTY or call **1.800.735.2929**

Section 1: Member Information

Last Name: _____ First Name: _____ Middle Initial: _____
Relationship to Member: ☐ Self ☐ Spouse ☐ Son ☐ Daughter
Authorized Representative Name: _____
Alliance Member ID Number: _____
Date of Birth (MM/DD/YYYY): _____
Sex: ☐ Male ☐ Female

Section 2: Member/Authorized Representative's Contact Information

Address (include apt/unit number): _____

City: _____ State: _____ Zip Code: _____

Office Contact Person Full Name: _____

Home Phone Number: _____ Cell Phone Number: _____

Email: _____

Section 3: Certification

I certify that, to the best of my knowledge, the information on this Member Request for Reimbursement Form and supporting documents provided is true and correct.

Signature: _____

Print Name: _____ Date: _____