Member Request for Reimbursement Form

Please use one (1) form for each health expense you are asking 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:

If you have questions, please call:

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: _____