MEMBER REQUEST FOR REIMBURSEMENT FORM

Please use one form for each health expense you are asking Alameda Alliance for Health (Alliance) to reimburse to you. Complete all sections of the form and attach the required bills. This way we can more quickly process your request.

Section A: MEMBER INFORMATION			
Last Name:	First Name:		Middle Initial:
Relation to Member: ☐ Self ☐ Spouse ☐ Son ☐ Daughter	Authorized Representative Name:	Sex: ☐ M ☐ F	Date of Birth: (MM/DD/YYYY)

Section B: MEMBER/AUTHORIZED REPRESENTATIVE'S CONTACT INFORMATION		
Alliance Member ID:		
Street Address (please include Apt/Unit Number):		
City:	State:	ZIP Code:
Home Phone:	Cell Phone:	

Section C: WHAT TO SUBMIT WITH THIS FORM

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. The Alliance ***cannot*** accept requests that are missing detailed bills.

When to submit: We will accept and review requests that we receive within 90 calendar days after the date the bill was paid. We ***cannot*** accept bills received *more* than 90 days after the date the bill was paid.

Section D: 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:

SUBMIT YOUR REQUEST

Mail this completed request form with your detailed bills to:

Alameda Alliance for Health
ATTN: Grievance & Appeals Department
P.O. Box 2818
Alameda, CA 94501-0818

If you have questions, contact the Alliance Member Services Department at **510.747.4567**
People with hearing and speaking impairments (CRS/TTY): **711/1.800.735.2929**