Member Reimbursement Form

Member Services: 1-855-580-1689 | TTY: **711 | Monday - Sunday, 8 a.m. to 8 p.m.**

HOW TO USE THIS FORM

Please use this form if you paid for medical services and want to be reimbursed.

Use one form for each bill you paid. Please include a copy of the bill and receipt showing you paid. Send to:

MeridianComplete
Attn: Medical Reimbursement Request
1 Campus Martius, Suite 700
Detroit, MI 48226

Keep a copy of everything you send us for your records.

MEMBER INFORMATION

Patient Name		Date of Birth	
Member Name		Member ID	
Address	City	State	Zip Code
Phone	PCP Who Wrote Referral	PCP number	

PROVIDER/BILLING INFORMATION

Provider Name		Provider Name	
Address		Address	
Phone		Phone	
Services		Services	
Dates of Service		Dates of Service	
Total Charges	Total Paid	Total Charges	Total Paid

NOTE: Add a seperate sheet for each item and supply the need documentation if you are reporting more than two services.

ADDITIONAL INFORMATION: Fill out all that applies

1. Was the service an emergency?	☐ Yes	☐ No
2. Was your primary care provider notified?	☐ Yes	☐ No - Explain below
3. Were you referred by your primary care provider?	☐ Yes	☐ No - Explain below

If services were not given by a MeridianComplete provider, please explain why.

Please explain why you are requesting reimbursement (attach additional sheets if needed).

I CERTIFY THAT THE ABOVE STATEMENTS ARE CORRECT

Member's Signature	Date

meridiancomplete
A WellCare Company