

# Clover Health

## Medical Direct Member Reimbursement (DMR) Form

Member Information:		
Member Full Name:		
Member ID#:	Birth Date (MM/DD/YYYY): ____/____/____	Phone Number: (____) ____ - ____
Address:		
City:	State:	ZIP Code:
Provider Information: (Ask your provider for this information or have them fill this out)		
Facility or Servicing Provider Name:		
Accepts Medicare Assignment? <input type="checkbox"/> Yes <input type="checkbox"/> No	Phone number:	
Address:		
City:	State:	ZIP Code:
Medical Information: (Ask your provider for this information or have them fill this out)		
Description of Service/Item Received:		
Description of Symptoms:		
Date(s) of Service:	Date of Illness/Injury:	
Procedure Code(s):	Diagnosis Code(s):	
Condition was related to: (if applicable) <input type="checkbox"/> Patient's Employment <input type="checkbox"/> Auto Accident <input type="checkbox"/> Other Accident (Description):		
Amount Member Paid:		

Other Insurance: (If applicable)		
Name of Other Health Insurance:	Policy Number:	
Address:		
City:	State:	ZIP Code:

**Please Include the Following:**

- Completed Member Claim Submission Form
- An Itemized Bill that includes:
  - Name and Address of Provider
  - Procedure Codes
  - Diagnosis Code
  - Date(s) of Services
  - Amount charged for each service

By signing below, I am stating the information provided above is, to the best of my knowledge, true and correct. I certify that, by completing this form, I am seeking monetary reimbursement from a federal health-care program for healthcare services and authorize the release of any medical information necessary to process this claim.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

CONFIDENTIAL COMMUNICATION: This transmission is intended only for the individual or entity to which it is addressed and contains information that is confidential. If you have received this communication in error, please delete the email and contact the sender immediately. This information may have been disclosed to you from confidential records and may be protected by federal and state law. This information may include confidential mental health, substance abuse, alcohol abuse and/or HIV-related information. Federal and state law prohibits you from making any further disclosure of this information without the specific written consent of the person to whom it pertains, or as otherwise permitted by law. Any unauthorized further disclosure in violation of the law may result in a fine or jail sentence or both. A general authorization for the release of this information may not be sufficient authorization for further disclosure.

Clover Health is a Preferred Provider Organization (PPO) plan and a Health Maintenance Organization (HMO) plan with a Medicare contract. Enrollment in Clover Health depends on contract renewal. This information is not a complete description of benefits. Call 1-888-778-1478 (TTY 711) for more information.