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? ☐ Yes ☐ 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) ☐ Patient's Employment ☐ Auto Accident ☐ 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:** _____