CARE IMPROVEMENT PLUS
Specialized care for Medicare beneficiaries

CLAIM FOR REIMBURSEMENT FORM

Please use a separate form for each physician or facility claim. Please complete all fields and attach the required documentation. Failure to submit necessary documentation may result in payment delay and/or claim denial.

Subscriber Information

Last Name First Name Middle Initial		Member ID Number	
Address	City	State	Zip
Home Phone	Work Phone		
Do you have other Health Insurance? ☐ Yes ☐ No	If yes, please provide Policy Number		
Name of Health Insurance Company	Type of Other Health Insurance ☐ Major Medical ☐ Dental ☐ Vision ☐ Hospital ☐ Physician ☐ Prescription Drug ☐ Other		

Medical Information

HEALTH CARE SERVICES: *Use this section to report any COVERED health service which has not already been reported to Care Improvement Plus by the provider of the service (the physician, clinical, ambulance company, private duty nurse, etc.)* ***Please attach copies of itemized bill and proof of payment*** *. Please be sure that duplicate bills are not submitted.*

Was this medical expense the result of an accident? ☐ Yes ☐ No
If yes, on what day did this injury or accident occur? ____/____/____ (MM/DD/YYYY)

Was this condition or injury job related? ☐ Yes ☐ No
If yes, have you filed for Workers' Compensation? ☐ Yes ☐ No

Have you been treated for the same condition within the last 24 months? ☐ Yes ☐ No
If yes, indicate date you were last treated? ____/____/____ (MM/DD/YYYY)

DATE OF SERVICE (MM/DD/YYYY)	PROVIDER (Name of Doctor, Laboratory, Ambulance Service, etc.)	SERVICE RENDERED (Office Visit, X-ray, etc.)	DIAGNOSIS	TOTAL

If the bill is from a Licensed Clinical Social Worker; Marriage, Family and Child counselor; Audiologist; or Occupation, Physical, or Speech Therapist, what is the name of the physician who ordered the service?

Dr. _____

Please mail to:
Care Improvement Plus
Member Reimbursements
351 W. Camden St., Ste 100
Baltimore, MD 21201

I certify that the information on this Member Claim Form is true and correct to the best of my knowledge. I authorize the release of any medical information necessary to process this claim.

X_____

X_____
SIGNATURE OF SUBSCRIBER OR AUTHORIZED REPRESENTATIVE DATE