OUT OF COUNTRY – MEMBER REQUEST FOR REIMBURSEMENT

And/Or Documentation of Out of Pocket for PRA Accrual

This form should be completed if a member has paid out of pocket for medical treatment or procedure, or prescriptions and is requesting reimbursement as these expenses may be eligible for sharing. If bills are not in English, the member should translate them prior to submitting.

PERSONAL INFORMATION (please print clearly)

PRIMARY CONTACT		Membership ID
Address		
City	State	Zip + 4
Home Phone	Member/Patient Name That Incurred Expenses	

PROVIDER INFORMATION (one form must be submitted for each)

PROVIDER NAME	Country Where
Describe Medical Event	

Description of Charge (Medical appointment, prescription drug, etc.)	Date of Service (MM/DD/YYYY) From	To	Amount Charged	Amount Paid by Member	Bill or proof of payment attached
					☐
					☐
					☐
					☐
					☐
					☐
					☐
					☐
	TOTAL CHARGED			**TOTAL FOR CONSIDERATION**	

SIGNATURE	Date

When you are submitting expenses for more than one family member, please use a separate form for each person. It is suggested that you make copies for your own use before you submit original bills.

If possible, the member should translate the bill or receipt if written in another language.

Reimbursement is made based on the rate of exchange in effect at the time the member paid the bills.

Your provider should submit associated bills on an Itemized Bill (IB) form. In the event that your provider is unable to do so, please provide any receipts or documentation given for the date(s) of service listed. This documentation is necessary in order for the expenses to be considered for sharing.

Check that each itemized bill is legible and contains ALL of the following information:

- ✓ Doctor's name
- ✓ Facility name and address
- ✓ Tax ID number
- ✓ Diagnosis codes (Icd9 codes)
- ✓ Procedure codes (CPT codes)
- ✓ Full breakdown of charges by service
- ✓ Receipt showing payment
- ✓ Include any discounts given by provider

Prescription charges may be eligible if related to an eligible medical event for up to a total of 6 months. Attach the personalized prescription information (usually a printout attached to the prescription bag) along with your receipt of payment. If unavailable, you can request a duplicate to be printed by your Pharmacist. This is required in order to be considered for sharing.

The personalized prescription information must include:

- ✓ Patient name
- ✓ Doctor's name
- ✓ Date Rx is filled
- ✓ Rx name
- ✓ Dosage
- ✓ Amount
- ✓ Days supply
- ✓ Pharmacy name and address
- ✓ Total charge
- ✓ Receipt

BILLS MISSING ANY OF THIS INFORMATION MAY BE RETURNED TO YOU

Please mail this completed form along with the requested documents/receipts to:

Impact Health Sharing | PO Box 3139, Farmington Hills, MI 48333 | (855) 378-6777 | Fax (954) 678-6970