

# Medical Reimbursement (DMR) Form

INSURED INFORMATION – ALL SECTIONS MUST BE COMPLETED			
Insured's Name ( as shown on the ID card) First M.I. Last		AgeRight Advantage Identification Number (as shown on ID Card)	
Insured's Street Address		Patient's Date of Birth Month Day Year	
City State	Zip Code	Daytime Phone Number (in case additional information is	
	For O	ffice Use Only	CUSTOMER CLAIM FORM
Please see the other side of this form for instructions and mailing information. Please print or type all information.			
PATIENT'S CONDITION AND TREATMENT			
Treatment was for Condition was due to  Illness Injury			If injury, give date  Month Day Year
What is the patient being treated for?	Fire	st date care was received  Month Day	for the illness or injury Year
ATTACHMENTS  Please check the types of documents you have attached copies of  Itemized bill(s) for this patient			
AUTHORIZATION			
I certify that the information on this form is complete and correct to the best of my knowledge. I authorize the release of any medical information necessary to process this claim.			
Signature of Insured		Date	

# SEE INSTRUCTIONS ON OTHER SIDE BEFORE MAILING

#### INSTRUCTIONS FOR FILING A CLAIM

This form is designed to help you file a claim for health care services received by you. If a doctor, hospital, or other health care provider has already filed a claim directly with AgeRight Advantage on your behalf, please do not send a Customer Claim Form for the same services.

# STEP 1. Complete the Insured Information section.

- •Please print or type.
- •All sections must be completed for processing. Make sure to write in your Identification Number as shown on your ID card including any letters in front of your number.
- •Please provide a daytime telephone number where you can be reached if more information is needed to process this claim.

# STEP 2. Complete the Patient's Condition (diagnosis) and Treatment section

STEP 3. Review the bills for health care services that you will be sending, and please keep a copy as bills cannot be returned.

Bills must show an itemized charge for each service the patient received. Each bill must show:

- •The patient's name.
- •The name, address, and tax identification number of the health care provider.
- •The date of each service, the charge for each service, and a description of each service.
- •The Referral Number for specialist care if your program requires referrals from your Primary Care Physician.
- STEP 4. Complete the Attachments section. If these same services were covered first by another health care plan (the patient's primary plan), make sure you have copies of the other plan's statements showing how each service was paid.

# STEP 5. Sign the Authorization.

### STEP 6. MAIL YOUR COMPLETED CLAIM TO:

AgeRight Advantage PO Box 4440 Glen Allen, VA 23058-4440