Direct Member Reimbursement Form

Medical Services

Please use this form for any medical reimbursement requests you may have.

Member Name:
Member Date of Birth:
Member Phone Number:
Member Mailing Address:
Health Plan ID Number:

Type of services received: (Example: Emergency Services)

____

Expected Reimbursement Amount: ____

Date of service: ____

Person Requesting Reimbursement:

☐ Member ☐ Family Member ☐ Friend ☐ Legal Representative

If request is made by anyone other than the Member, please provide the following information:

Name: ____

Phone Number: ____

Mailing Address: ____

(Please note any reimbursement request not requested by the member must be submitted with appropriate legal documents in order to be processed.)

Documents required in order to process your request:

☐ Proof of Payment (doctors' receipt, credit card statement and bill, cancelled check) ☐ Medical Records
☐ Itemized Bill

Requestor Signature _____________________________________ Date: _______________

Please mail reimbursement request to:

Leon Health Inc.,
Attn: Claims Department
P.O. Box 668230
Miami, FL 33166

This information is available for free in other languages. Please call our Member Services number at 305-541-5366 or toll-free at 1-844-969-5366 (TTY 711), seven days a week from 8:00 am to 8:00 pm. Esta información está disponible de forma gratuita en otros idiomas. Por favor, llame a nuestro Departamento de Servicios a los Afiliados al 305-541-5366 o gratuitamente al 1-844-696-5366, (TTY 711), los siete días de la semana de 8:00 am a 8:00 pm. Leon Health, Inc. is an HMO plan with a Medicare contract. Enrollment in Leon Health, Inc. depends on contract renewal

H4286_MbrRmbrsmt_C