MEMBER CLAIM FORM REIMBURSEMENT (REFUND) REQUEST

SCAN Case #:

MEMBER INFORMATION	
Name:	SCAN Member ID:
Address:	
Phone:	Date of Birth:
Gender: ☐Male ☐Female	Other insurance (if any):

PROVIDER INFORMATION	
Provider/Facility Name:	
Address:	
Date(s) of Service:	Expected Amount:
Place of Treatment: ☐Office ☐Hospital/ER ☐Urgent Care ☐Clinic ☐Services rendered outside the U.S. ☐Other:	

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Please provide the <u>required</u> documents listed below. Any missing information will be returned to you as incomplete. We cannot process your refund request until we have all this information.

Please provide the following <u>required</u> documents:

- An itemized bill. For example:
  - It must show the Medical provider's or supplier's name and address, a description of each medical service or supply, amount(s) charged for each service or supply and date(s) that you received the service(s) or supply.
- Supporting documentation or information for example: Medical records, doctor notes, referral, prescription, itemized bill, etc.
- Proof of payment. For example:
  - Provider statement that shows a payment made
  - Official receipt that shows provider information
  - Credit card statements (for security, please block out your account information)
  - Cancelled check (front and back)
- Power of Attorney or Appointment of Representative form (found on SCAN's website). Only needed if you are not the member but are filing claim on behalf of a member

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CLAIM INFORMATION**
IMPORTANT: Explain in detail the illness or injury for which you received treatment and the reason you went to this provider (attach a separate page, if needed). *For example, "on 2/1/20XX, while I was on a cruise, I fell on the deck and got a bad sprain to my right ankle. I saw the ship doctor, Dr. John Smith, who gave me a brace and I paid $175 on my credit card."*

SIGNATURE OF MEMBER OR REPRESENTATIVE*	
Print Name:	Relation:
Signature:	Date:

IMPORTANT—SEE OTHER SIDE FOR INSTRUCTIONS

- Use this form to file your refund request for payments you made. You must submit these documents within one year from when the services were received.
- We can't process your refund request until we have all this information, so please send us this completed form with all bills and supporting documentation as soon as possible. An incomplete Claim Form or missing documentation will be returned to you with a letter detailing what information is needed.
- Services received from more than one provider cannot be combined on one Claim Form. A separate Claim Form must be submitted for each provider. Please keep copies of your bills and supporting documentation for your personal records.
- It may take up to 60 days to process your refund request.

If you have any questions, we are here to help. Please call Member Services number at 1-800-559-3500 (TTY: 711). Our hours are 8 a.m. – 8 p.m., seven days a week from October 1 to February 14. From February 15 to September 30 hours are 8 a.m. – 8 p.m. Monday through Friday Messages received on holidays and outside of our business hours will be returned within one business day.

Please fax or mail this completed form, together with the itemized bill(s) and supporting documentation (including proof of payment, if applicable) to:

Delta Care USA P.O.
Box 1810
Alpharetta,GA 30023
