



### MEMBER CLAIM FORM

To assist you in seeking reimbursement for covered medical services that you paid, please complete this form and send it along with an **itemized bill, receipts/proof of payment** to Unity Health Insurance. This includes reimbursement for services received in a foreign country.

If you are seeking reimbursement for prescription drugs received in the United States, please use the Prescription Claim Form.

Complete the following:

Subscriber Name: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Subscriber #: \_\_\_\_\_

Reason for Visit – if claim is from a foreign country, please indicate where the charges occurred:

\_\_\_\_\_  
\_\_\_\_\_

Fill in the date(s) of service, description (procedures) and the claim total below:

<u>Date(s) of Service</u>	<u>Description (Procedures)</u>	<u>Amount Paid</u>
1.		\$
2.		\$
3.		\$
4.		\$
5.		\$
6.		\$
7.		\$
	<b>Total Amount:</b>	

If you have any questions, please email Customer Service by logging on MyUnity at [unityhealth.com](http://unityhealth.com) or call M-F between 7:00 am and 5:00 pm at 800-362-3310.

**Note:** The reimbursement check will be made out to and sent to the policyholder of the health plan.