MEMBER CLAIM FORM FOR FOREIGN PROVIDER REIMBURSEMENT (REFUND) REQUEST

SCAN CASE #:

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

FOREIGN 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:	

MEMBER FOREIGN PROVIDER REIMBURSEMENT (REFUND) REQUEST

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

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

- Itemized bill or invoice from the foreign provider
- Power of Attorney or Appointment of Representative form (found on SCAN's website) if you are not the member but are filing the claim on behalf of a member
- Supporting documentation or information. For example: Medical records, provider notes, referral, prescription, itemized bill, etc.

CLAIM INFORMATION**

IMPORTANT: Explain in detail the illness or injury for which you received treatment and the reason you went to this foreign provider (attach a separate page, if needed). *For example, "on 2/1/20XX, while I was in Mexico, I fell on the sidewalk and got a bad sprain to my right ankle. I went to the Emergency Room for X-rays and they sent me the attached invoice."*

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

IMPORTANT—SEE OTHER SIDE FOR INSTRUCTIONS

- Use this form to ask us to pay a bill you received from a provider. We can't process your request until we have all the information indicated on this form, 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. Please send a separate Claim Form for each provider. Keep copies of your bills and supporting documentation for your personal records.
- It may take up to 60 days to process your provider payment request.

If you have any questions, we are here to help. Please call Member Services 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:

SCAN Health Plan
P.O. Box 22698
Long Beach, CA 90801-5616
Fax: (562) 426-2150
