Clover Health

Reimbursement Instructions

How to complete this Direct Member Reimbursement (DMR) Form

When to use this form:

- Fill out this form if you're asking for a medical, dental, vision, hearing aid, or vaccine reimbursement and you paid a doctor, healthcare professional, or service provider who did not bill us directly.
- Do not use this form for prescription drug claim reimbursements. Visit cloverhealth.com or call the CVS customer service number on your member ID card to get a prescription drug claim form.

How to fill out this form:

1. Complete each section. Print clearly in black ink only. If you need another form, you can download the PDF at **cloverhealth.com/dmr** and print it.
2. Itemized receipts can also be submitted with this form (optional).
3. Sign and date the bottom of the completed form. Appointed representatives must have an Appointment of Representative form on file, or you can submit one with this form. You can find an Appointment of Representative form at **cloverhealth.com/aor**.

Where to send the completed form:

1. Fax the completed form to **1-888-240-7243**.
2. Mail the completed form to:
   Clover Health, Attn: Direct Member Reimbursement
   P.O. Box 2092
   Jersey City, NJ 07303
3. Or you can send the completed form via secure email to **PO_Box_2092@cloverhealth.com**.

Things to remember:

1. Please submit the form within 365 days from the date you received the service or item.
2. If the form is incomplete, processing delays may occur while we find the needed information.
3. If we approve your request, it can take up to 45 days to send payment once we have all the required information.

Acknowledgment

I understand it is a crime to fill out this form with information I know is false. I understand the submission of a claim is not a guarantee of payment, or payment in the full amount. I understand if the services are deemed covered services then the health plan will reimburse me up to the benefit amount minus any applicable deductibles, coinsurance, or copays. I understand Clover Health may need to disclose the information on the form to other persons and entities to process the claim.

Clover Health

Type of Reimbursement:
☐ Medical ☐ Dental ☐ Vision

Member information (print clearly):		
Member full name:		
Clover Health member ID#: C P ___ ___ ___ ___ ___ ___ ___	Birth date (MM/DD/YYYY): _____/_____/_____	Phone number: (_____) _____-_____
Address:		
City:	State:	ZIP code:
Email address (optional):		

Doctor, healthcare professional, or supplier information:		
Provider name:		
Does the provider accept Medicare? ☐ Yes ☐ No	Phone number: (_____) _____-_____	
Address:		
City:	State:	ZIP code:

Claim request (information must match your itemized bill):	
Date of service or procedure (MM/DD/YYYY): _____/_____/_____	Amount paid: ___ ___, ___ ___ ___. ___ ___
Description of procedure(s), service(s), or item(s):	

Signature	
By signing and submitting this form, I certify that the information is true and correct.	
Member or authorized representative signature:	Date: _____/_____/_____

Questions? We're here to help. Just call us at **1-888-778-1478** (TTY 711) from 8 am to 8 pm local time, 7 days/week.

Between April 1st and September 30th, alternate technologies (for example, voicemail) will be used on the weekends and holidays.