**Member Reimbursement Form**

**Attention Plan Members:** This form is to be used for reimbursement of covered services provided in accordance with your AdventHealth Advantage Plans benefits. **Please include an itemized statement and proof of payment with the completed reimbursement form.**

**Member Name (please print):** ___________________________ **Member ID #:** _____________

**Member Address:** ____________________________________________________________

________________________________________

**Signature:** ____________________________________________ **Date:** __________________

**Must be signed by member or member’s authorized representative. If signed by authorized representative, provide the following information:**

**Name:** ________________________________________________

**Address:** ________________________________________________

**Phone Number:** (______) _______ - _______ **Relationship to Member:** _________________

**Date of Service** | **Procedure Code (if available)** | **Description of Services** | **Diagnosis Code (if available)** | **Billed Amount**
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By submitting this Member Reimbursement Form, I (member named above) certify that I personally received these services and **request reimbursement according to my plan benefits.**

Please fax or mail the signed and completed form, or submit it online:

**FAX:** 321.434.5655 (Attn: Benefits Reimbursement Unit)

**MAIL:** Benefits Reimbursement Unit, AdventHealth Advantage Plans, 6450 US Hwy. 1, Rockledge, FL 32955

**MEMBER PORTAL:** myAHplan.com/myportal

For further assistance, please call Customer Service toll-free at 1.855.882.6467 (TTY/TDD relay: 1.800.955.8771) weekdays from 8 a.m. to 8 p.m. and Saturdays from 8 a.m. to noon. From October 1 to March 31, we’re available seven days a week from 8 a.m. to 8 p.m.

**AdventHealth Advantage Plans is administered by Health First Health Plans. Health First Health Plans is an HMO plan with a Medicare contract. Enrollment in Health First Health Plans depends on contract renewal.**

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