



MEMBER REIMBURSEMENT REQUEST FORM

INSTRUCTIONS: Please complete this form, attach bill from provider, proof of payment and mail to: Physicians United Plan (HMO), <P.O. Box 4960, Winter Park, FL. 32793>. Or fax to <(407) 937-2511.> Incomplete forms will be returned to you for missing information.

Member Name: _____ Member ID# _____

Describe Service/Supply received:

Provided to me by: _____
(name, address and tel. number of provider)

Reason for service: _____
(describe diagnosis, nature of illness/injury)

Is claim related to an accident? Yes _____ No _____ If yes, explain

Is claim related to an emergency? Yes _____ No _____ If yes, explain

Amount Billed by Provider _____ Amount You Paid _____

Mail check to: _____

Daytime telephone number: _____

Please read and sign below:

I authorize all providers of health care to provide Physicians United Plan HMO ("PUP") information concerning health care advice, treatment or supplies provided to me. This information will be used to evaluate my claim for benefits. I know I have a right to receive a copy of this authorization upon request and agree that a photographic copy of this authorization is as valid as the original.

Any person who knowingly and with intent to injure, defraud, or deceive any insurer, files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

(Signature)

Date _____