

If a Member Reimbursement Form is being submitted by an Authorized Representative, please complete and include the *Appointment of Representative (AOR) Form*, or any legal documentation verifying personal representation, with your request. We require verification of the authority of an Authorized Representative before the request can be processed. You can find the AOR Form on our website at carepartnersct.com/aor.

☐ I am completing this form as an Authorized Representative to the subscriber.

Member Information

M.I. Last name

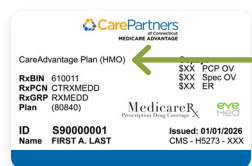
Date of birth

Member ID number

Plan type

 HMO

☐ PPO



Find your
plan type
on your
member
ID card.

Service Information (Include any additional information on separate sheet)

Name of service provider

Street address

City

State ZIP

IF SERVICES WERE PERFORMED OUTSIDE USA

Country of service

Language of bill/receipt

Currency of bill

In what setting did you receive treatment?

☐ Office ☐ ER ☐ Hospital ☐ Clinic ☐ Other

Describe the items/services received¹
(e.g., lab work, ER visit, flu shot, eyewear, durable
medical equipment,² dental services, etc.)

Service date(s)

Procedure code (optional)

Reimbursement Information

Amount of reimbursement you are requesting

\$. ☐ Amount is in another currency (as specified on page 1)

Please include proof of payment and itemized receipt.³

Check which of the following acceptable proof of payment you are attaching to this form

- ☐ A copy of the front and back of the cancelled check written to the provider or the bank encoded front of the check written to the provider.
- ☐ A credit card statement or receipt with itemized bill and authorization, if applicable.
- ☐ A statement from the provider, on the provider's letterhead with authorized signature, indicating payment was made.

Signature

I attest that the information is accurate and complete.

Signature

Date

Instructions



Please mail this completed form to:

CarePartners of Connecticut, Inc.

Member Reimbursement

P.O. Box 518

Canton, MA 02021-0518

For more information:

Call Member Services at

1-888-341-1507 (HMO)/

1-866-632-0060 (PPO) (TTY: 711)

8 a.m.–8 p.m., 7 days a week

(Mon.–Fri. from Apr. 1–Sept. 30).

¹CarePartners of Connecticut may require prior authorization for certain services and items, including drugs, devices, and equipment as a condition of payment. Refer to your Evidence of Coverage booklet for your plan's guidelines.

²Prescription required for durable medical equipment purchase.

³A receipt for purchased items, with the provider's name and address preprinted on the receipt, with items listed and the amount paid.