Alliance Coal Health Plan

MEMBER REIMBURSEMENT CLAIM FORM

Instructions

1. Complete all the sections on this form and include supporting documentation such as receipts.
2. Make a copy of this completed form and documentation for your records. (Claim information cannot be returned.)
3. Send this completed form and original documentation to Member Services.

Mail: Alliance Coal Health Plan
PO BOX 1950
Tulsa, OK 74101-1950

Email: info@alccm.com

Member / Patient Information

Member ID #	Last Name	First Name	MI	Date of Birth

Street Address	City	State	Zip

Daytime Phone #	Email Address

Other Insurance (if patient is also covered by another insurance)

Name of Insurance	Policy Number	Policy Effective Date

Employee Information (if not patient)

Member ID #	Last Name	First Name	MI	Date of Birth

Expense Details

Provider Name	Provider Address	Date of Service
Service Received	Diagnosis Code (required for Medical claims, IF the diagnosis is not on the attached supporting documentation)	Reimbursement Amount

Member / Patient / Guardian Certification

Any person who knowingly, and with intent to defraud, files a statement of a claim containing any materially false, incomplete, or misleading information is guilty of a crime. I certify that the expenses for which I am seeking reimbursement have been incurred by me, or by an eligible member under my plan. I authorize the release of any medical or other information necessary to process this claim.

Member / Patient / Guardian Signature　　　　Date