2024 Direct Member Reimbursement Request Form

For Medicare plan members

Medica

eVisit with Amwell

A	HERE'S HOW TO COMPLETE THIS FORM

1. Fill out Section 1 completely.
2. Please remember: To receive reimbursement, you must attach copies of your itemized receipt(s) and proof of payment to this form.
3. Mail this completed form with attached receipt(s) to the address for your plan type. Plan types can be found on the front of your Medica ID card.

Note: Please submit one (1) request per reimbursement form. If you have more than one service to submit, please fill out separate forms for each request.

If you're enrolled in:	**If you're enrolled in:**
• **For Medica Group Advantage Solution℠ (PPO) Plan**	• **For Medica Group Prime Solution℠ w/Rx (Cost) Plans**
Mail form to:	**Mail form to:**
Medica Claims P.O. Box 21342 Eagan, MN 55121	Medica Claims P.O. Box 30990 Salt Lake City, UT 84130

Please allow 60 calendar days from the date Medica receives your form for your reimbursement check to be mailed to you. Reimbursement requests must be made within 365 days from the date of service. You may submit multiple reimbursement requests on separate reimbursement forms for services up to the annual limit(s).

1	REIMBURSEMENT INFORMATION	
	Member information	
	Member name (as it appears on your Medica ID card):	
	Date of birth: ___ / ___ / _____	Phone number:
	Medica ID number:	Group number:
	Visit information	
	Facility name: **Online Care Network II PC**	
	Facility location (City, State, ZIP): **75 State Street 26th Floor, Boston, MA 02109**	
	Date of service: ___ / ___ / _____	Total amount you paid the provider*:

*You will be reimbursed for covered services.

Have questions? We're here to help.

Call the Member Services number on the back of your Medica ID card. Visit **Medica.com/Forms** for additional copies of this form.