VIVA MEDICARE

I paid out-of-pocket for covered medical, vision or dental services and am asking to be reimbursed (paid back).

Member Reimbursement Form

1) Fill out Sections 1-5 of this form. Please use dark ink and print clearly.
2) Enclose your original receipt that shows proof of payment and your itemized statement that shows the full list of services you received and the charges. Do not staple or tape documents to this form.
3) Keep copies for your records. Receipts and statements will not be returned.
4) Mail the completed form to VIVA MEDICARE no later than one (1) year after the date of service.
5) It may take up to thirty (30) calendar days after we receive your form and documents for you to be reimbursed (paid back).

Section 1 – Member Information

Member Number (on your member ID card)	Member Name	
Address Line 1	Date of Birth	Phone Number
Address Line 2	City	State ZIP code

Section 2 – Provider Information

Dentist or Doctor Name
Practice/Business Name
Address Line 1
Address Line 2
City, State Zip

Section 3 - Comments

Description/Explanation of claim:

Section 4 – Enclose Receipts and Statements

Receipts and statements must show:

- Your name
- Date of service
- Provider's name and address
- Diagnosis and procedure codes (for medical care)
- Itemized charges for the services you received (not a treatment plan)
- Proof of payment showing when/how you paid

Contact your provider if you need additional information.
Receipts in a non-English language must be translated before sending.

Section 5 – Signature

The above statements and enclosed receipts are true and complete to the best of my knowledge.

X _____ _____

Signature Date

See other side for mailing instructions.

Mailing Instructions

Mail to:
VIVA MEDICARE Claims Department
417 20th Street North, Suite 1100
Birmingham, AL 35203

Questions?

Call Member Services:
1-800-633-1542 (toll-free); TTY: 711
Monday - Friday, 8 a.m. - 8 p.m.
(Oct. 1 to Mar. 31, 7 days a week, 8 a.m. - 8 p.m.)

VIVA HEALTH complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex.ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-633-1542 (TTY: 711). 注意：如果您使用繁體中文，您可以免費獲得語言援助服務. 請致電 1-800-633-1542 (TTY: 711).