MiCare
Federated States of Micronesia

P.O. Box 2156 Kolonia, Pohnpei FM 96941
Tel: (691) 320-2549 /5865 Fax: (691)320-5693
Email : info@micareplan.fm

REQUEST FOR REIMBURSEMENT

Name of Patient: _____ Insurance ID Number: _____

Name of Subscriber: _____ Insurance ID Number:_____

Group Name:_____ Effective Date of Coverage:_____

Group Account Number:_____ Date of Birth:_____ Type of Plan: ☐ Basic ☐ SR ☐ SN

Mailing Address: _____ _____ _____ _____
P.O. Box or Street Address | City | State | Zip Code

Tel. Number: _____ _____ Fax No: _____ Email: _____
Home | Work

Reimbursement Check to be: ☐ Mailed to address above ☐ I will pick up ☐ _____

1. Check applicable box for the state or country where the claims incurred:

☐ Pohnpei ☐ Chuuk ☐ Kosrae ☐ Yap ☐ Guam ☐ Philippines ☐ Hawaii ☐ US Mainland ☐ Other_____

2. Check Type of reimbursement:

☐ Pharmacy ☐ Office Visit ☐Hospital ☐ Laboratory ☐ Dental ☐ Optical ☐ Emergency ☐ Other _____

3. Name of Hospital/Clinic/Pharmacy checked in question #2:_____

4. Address of Facility: _____

5. Date of Service: _____ 6. Amount requested for Reimbursement: $_____

7. Nature of Payment (Please Check) ☐ Cash ☐ Credit Card ☐ Check (Attach Proof of Payment)

8. Is Original Receipt attached with this form? ☐ Yes ☐ No If no, Reason:_____

All Claims must be submitted within 1 year from the date of service. Incomplete claims and claims submitted after 1 year will not be Accepted. Micare will not request documents from the providers. A detailed English translation must be included with all non-English Claims. Please use one form per provider/member and indicate the amount paid for each service.

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize the release of all medical and/or hospital records pertaining to this care

_____ _____
Patient's Signature | Date Signed

FOR OFFICE USE ONLY **CONTROL NO._____**

Received by: _____ Date:_____ Member's Status: ☐ Active ☐ Inactive Verified by: _____ Date:_____

Claims Status: ☐ Covered Charges ☐ Denied/Returned Reviewed By: _____ Date:_____

Processed by: _____ Date:_____ Checked by: _____ Date: _____