Member Reimbursement Request Form

You will receive a response within 30 days of iCare receiving this form.

Completed forms may be mailed to:
iCare
1555 N. RiverCenter Dr. Suite 206
Milwaukee, WI 53212
Attn: PA Department

Or faxed to:

414-231-1026

Member Information			
Member Name:		DOB:	
Member ID#:		Phone:	
Mailing Address:		City:	
State:		Zip:	

Physician Information			
Physician Name:		Phone:	
Address:		City:	
State:		Zip:	

Services/Items Purchased
Provide as much detail as possible.
Please include additional documentation, such as receipts and a physician order, if available.
Attach additional pages, if needed

Date of Purchase	Description	Quantity	Total Cost

Form continued on next page

Reason for purchase:
Attach additional pages as needed

Signatures

X ______________________________________
Signature of *i*Care Member or Legal Representative*

____
Date

X ______________________________________
Signature of Witness

____
Date

Signature of Witness is only required if member is signing with a mark such as “X”.

*** If signed by a legal representative, please complete:**

Member is one or more of the following (circle all that apply):

Minor   Incompetent   Incapacitated   Deceased

Nature of Legal Authority (circle all that apply):

Custodial Parent   Legal Guardian   Activated Power of Attorney for Healthcare   Executor of Estate of Deceased

NOTE: When the member is an adult and you are signing as the legal representative, proof is required of the legal representative relationship in order to release information. Attach Guardianship, Power of Attorney – Health Care, or Executor paperwork as documentation.

THIS DOCUMENT WILL NOT BE HONORED UNLESS ACCOMPANIED BY THE REQUIRED DOCUMENTATION.