iCare Member Reimbursement Form

To request reimbursement, complete and print this form. Enclose a legible copy of your itemized receipt(s), and send them to the following address. Be sure to keep a copy for your records.
iCare Health Solutions, PO Box 495902, Cincinnati, OH 45249

PATIENT

How are you related? (check one)

☐ Member ☐ Domestic Partner ☐ Dependent Parent ☐ Disabled Dependent
☐ Spouse ☐ Child ☐ Full-Time Student ☐ Other

Date of Birth: (*mm/dd/yyyy*) Sex: ☐ Male ☐ Female
Last Name: First Name: MI:
Address:
City: State: Zip:

MEMBER

Full Member Subscriber ID:
☐ Member information below is the same as the patient

Date of Birth: (*mm/dd/yyyy*) Sex: ☐ Male ☐ Female
Last Name: First Name: MI:
Address:
City: State: Zip:

CLAIM

Date of Service: (*mm/dd/yyyy*)

Exam	$
Frame	$
Lens	$
Lens Tints or Coatings	$
Contact Lens Exam/Fitting Evaluation	$
Contacts	$
Total	$ 0

Lens Type : (*choose one*)
☐ Single
☐ BiFocal
☐ Trifocal
☐ Progressive
☐ Lenticular
☐ Post-cataract eyewear*

Surgery Date:

PROVIDER

Last Name: First Name: MI:
Office Name:
Address:
City: State: Zip:

PRINT AND SIGN

I attest that the information I have provided on this form is accurate and complete. I have read and acknowledge the fraud warning. I understand that this provider is not affiliated with iCare and that iCare does not guarantee reimbursement.

Claimant Signature: Date:

FRAUD STATEMENT

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree. (Note: Depending on the state where you live, additional penalties may apply).

To learn about your privacy rights and how your protected health information may be used, see the iCare Health Solutions Notice of Privacy Practices on myicarehealth.com.

* This applies only to Aetna PPO