



# Member Claim Reimbursement Form

If you paid for a health expense out of pocket that you believe should have been covered by Community Health Plan of Washington (CHPW), you can ask us to pay you back for covered services up to the allowed benefit amount. Please note that all referral requirements and authorization requirements must be met before reimbursement can be considered.

To make sure you are giving us all the information we need to make a decision, you can fill out this form and return it to us. You don't have to use the form, but it will help us process the information faster. With this completed form, send your bill and documentation of any payment you have made. It's a good idea to make a copy of your bill and receipts for your records. You must submit your claim to us within 12 months of the date you received the service or item.

To request reimbursement for health expenses, fill out the form below and send it to us by mail or online using our secure member portal, myCHPW.



**CHP Claims**  
P.O. Box 269002  
Plano, TX 75026-9002



**mychpw.chpw.org.**

**Questions?** Call the CHPW Customer Service team for your specific plan:

**Apple Health (Medicaid):**  
1-800-440-1561 (TTY: 711)  
8:00 a.m. to 5:00 p.m.  
Monday to Friday

**Medicare Advantage:**  
1-800-942-0247 (TTY: 711)  
8:00 a.m. to 8:00 p.m.  
seven days a week

**Individual & Family:**  
1-866-907-1906 (TTY:711)  
8:00 a.m. to 5:00 p.m.  
Monday to Friday

Community Health Plan of Washington is an HMO plan with a Medicare contract and a contract with the Washington State Medicaid program. Enrollment in Community Health Plan of Washington depends on contract renewal. Community Health Plan of Washington complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Under Washington law, people have a right to be free from discrimination because of race, creed, color, national origin, sex, veteran or military status, sexual orientation, or the presence of any sensory, mental, or physical disability or the use of a trained dog guide or service animal by a person with a disability. If you need an accommodation, or require documents in another format or language, please call 1-800-440-1561 (TTY: 711) Monday to Friday, 8:00 a.m. to 5:00 p.m. ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-440-1561 (TTY: 711). ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-440-1561 (телефакс: 711).



### Member Information:


First Name	Last Name	Member ID Number
Date of Birth		
Mailing Address		City, State, ZIP

### Provider Information:

Provider Name <i>(Example: Jane Johnson)</i>	
Facility Name <i>(Example: Evergreen Massage Services)</i>	
Provider and/or Facility Address	City, State, ZIP

### Service Information:

Date of Service	Procedure Code	Diagnosis Code
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 Proof of payment is required (Example: a receipt).

#### “Where do I get provider and service information?”

After you've seen your provider, your provider should give you an invoice or a superbill. It will list these details. If you aren't sure how to get your invoice or superbill, or aren't sure it has the information you need, you can call CHPW Customer Service.

**TIP:** You can hover your cursor over an entry field for more information.