NetCare
Life & Health Insurance

424 West O'Brien Drive
Julale Center, Suite 200
Hagatna, Guam 96910
Tel: (671) 472-3610
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REQUEST FOR REIMBURSEMENT

Date Received: _____ CSR: _____

Name of Member: _____ Member/SS No. _____

Name of Subscriber: _____

Group Name: _____ Plan: _____

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

Telephone Number: _____ _____ _____
Work | House or Cell | Email Address:

Reimbursement Check to be: ☐ Mailed to address above ☐ Picked up ☐ Other

1. Check applicable box for the state of country for this reimbursement submission:
   ☐ GUAM ☐ PHILIPPINES ☐ U.S. ☐ TAIWAN ☐ PALAU ☐ OTHER: _____
2. Check type of reimbursement:
   ☐ OFFICE VISIT ☐ PHARMACY ☐ HOSPITAL ☐ EMERGENCY ☐ VISION ☐ OTHER
3. Total amount paid out of pocket/requested for reimbursement: $ _____
4. Details: _____
5. Name of provider/facility: _____
6. Address/location of facility: _____ Date of Service: _____
7. Was payment made with: ☐ CASH ☐ CREDIT CARD ☐ CHECK (attach proof of payment)
8. Is a claim form attached? ☐ YES ☐ NO Is original receipt attached? ☐ YES ☐ NO

All submissions must include original receipts and a completed claim form from the provider which includes required CPT/ICD9 codes. All claims must be submitted within 90 days of the date of service. Claims submitted without the required documents, and claims filed past 90 days will be returned. If a claim is returned for missing documents, it must be re-submitted with all necessary documents within 90 days of the date of service. (NetCare will not request supporting documents from providers). **Reimbursement requests for services rendered in Asia and the Philippines must include detailed medical notes from the Physician/Facility for each service rendered and each prescription drug dispensed (translated into English).** Dental and pharmacy claims must also include support documents/pharmacy labels/claim forms. Dental claims for services rendered in the Philippines must include a tooth chart. Pharmacy claims from Asia/Philippines must also include supporting medical notes. **(Use one form per provider).**

AUTHORIZATION TO RELEASE INFORMATION

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

_____ _____
Member's Signature | Date Signed

FOR OFFICE USE ONLY

Date submitted to Claims Department: _____ Submitted To: _____

Returned for supporting documents: _____

Date Returned: _____

Check No: _____ Amount: _____ Member's Signature: _____ Date: _____