



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			
<i>Provide as much detail as possible. Please include additional documentation, such as <u>receipts and a physician order, if available.</u> Attach additional pages, if needed</i>			
Date of Purchase	Description	Quantity	Total Cost



Form continued on next page

<p>Reason for purchase: <i>Attach additional pages as needed</i></p>

Signatures	
X _____ Signature of <i>iCare</i> Member or Legal Representative*	_____ Date
X _____ Signature of Witness Signature of Witness is only required if member is signing with a mark such as "X".	_____ Date

*** 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.