Children's Hospital LOS ANGELES®

Reimbursement Request Form

INSTRUCTIONS

To process your reimbursement request, this form must be fully completed, signed, and returned with all required documents. You must attach a copy of your receipt that shows the dollar amount of your request, when the service occurred, and when it was paid. Please allow up to 30 days for review and processing after you submit your request for reimbursement.

Please submit to:

Mail: Pinnacle Claims Management, Inc.
P.O. Box 2220
Newport Beach, CA 92658

Email: **MERP@pinnacletpa.com**

EMPLOYEE INFORMATION

Name	Facility	Phone Number

Address

City	State	Postal Code

Is this a new address?

☐ Yes ☐ No

EXPENSE INFORMATION (Please see the back of this form for a description of expense types.)

Type of Expense	Patient Name	Date of Service	Health Plan Carrier/ Service Provider	Amount
☐ Out Of Pocket Medical Expenses				
☐ Out Of Pocket Medical Expenses				
☐ Out Of Pocket Medical Expenses				
☐ Out Of Pocket Medical Expenses				
☐ Out Of Pocket Medical Expenses				
☐ Out Of Pocket Medical Expenses				
☐ Out Of Pocket Medical Expenses				
			Total Expenses:	

SIGN AND ACKNOWLEDGE

I attest that the information contained in this Request for Reimbursement is true and accurate. I am an eligible participant in the WSP program, enrolled in a health plan, and seeking reimbursement for a medical health care service covered under my health plan. I understand that if I provide incomplete, false or misleading information, my Request for Reimbursement may be delayed or denied. I agree to indemnify and hold Pinnacle Claims Management, Inc. harmless from any liability for payment of benefits made based upon any of information that is inaccurate or false and to repay any benefits that I incorrectly received.

Signature	Date (mm/dd/yyyy)

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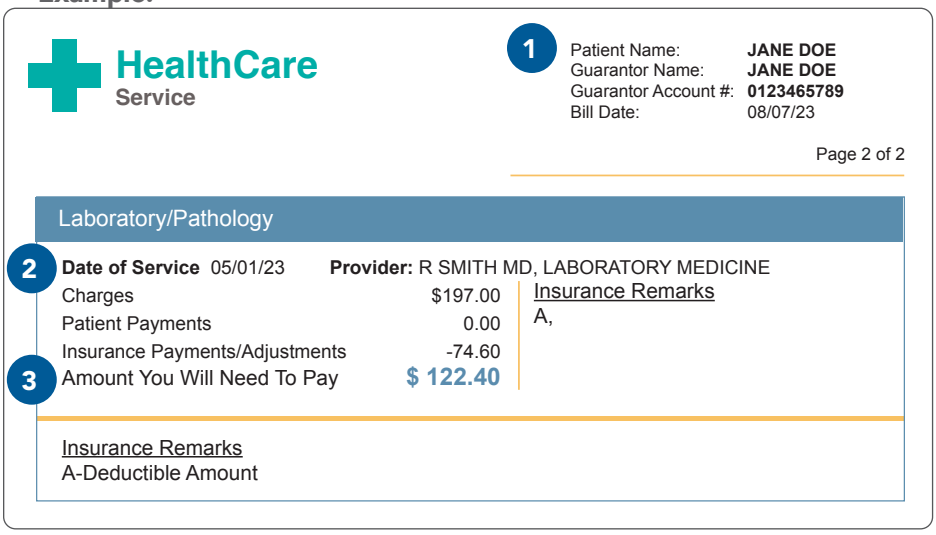
ACCEPTABLE RECEIPT CRITERIA

1. Patient name must be listed to associate the document with person seeking reimbursement.
2. Date of service must be listed and in the current plan year
3. Patient responsibility (copay, coinsurance, deductible)/goods purchased (Rx, medical equipment, etc.) must be listed on the documentation/receipt, and dated in the current plan year
4. If an Explanation of Benefits (EOB) is provided, it must also include the name of person receiving goods/services

Example:



HealthCare Service

1 Patient Name: **JANE DOE**
Guarantor Name: **JANE DOE**
Guarantor Account #: **0123465789**
Bill Date: 08/07/23

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Laboratory/Pathology

2 **Date of Service** 05/01/23 **Provider:** R SMITH MD, LABORATORY MEDICINE

Charges	$197.00
Patient Payments	0.00
Insurance Payments/Adjustments	-74.60
3 Amount You Will Need To Pay	$ 122.40

Insurance Remarks
A,

Insurance Remarks
A-Deductible Amount

REIMBURSABLE EXPENSE TYPE

Out-of-Pocket Medical Expenses:

Your share of medical costs after your Health Plan pays its portion of expenses. Out-of-pocket costs include coinsurance, copayments, and deductibles. This amount will never include an amount that exceeds the covered charge for out-of-network providers (also called "balance-billed charges") or health care expenses that aren't covered on your health plan.

FOR MORE INFORMATION:
PHONE (866) 642-2932 I FAX (949) 253-5420 I EMAIL: MERP@pinnacletpa.com

PINNACLE™ CLAIMS MANAGEMENT, INC.