I paid out of pocket and am requesting reimbursement for a covered service.

Member Reimbursement Form

1) Fully complete Sections 1-4 of this form. Please use dark ink and print clearly.
2) Enclose your original receipts and itemized statements.
3) Keep copies for your records. Receipts will not be returned.
4) Mail the completed form to VIVA HEALTH no later than one (1) year after the date of service.
5) A response to your request will be made within thirty (30) days.

Section 1 – Member Information

Family ID Number (on your ID card)	Member Name (who received services)	
Address Line 1	Date of Birth	Phone Number
Address Line 2	City	State/ZIP code

Section 2 – Comments

Description/explanation of claim:

Section 3 – Enclosed Receipts and Itemizations

Your receipts and itemizations should contain:

- Your name
- Date of service
- Provider's name and address
- Diagnosis and procedure codes
- Itemized charges
- Proof of payment

Contact the provider if you need additional information.

Section 4 – Signature

The above statements and enclosed receipts are true and complete to the best of my knowledge.

X ____ ________________________

Signature Date

Section 5 – Mailing Instructions

Mail to:
VIVA HEALTH Customer Service Department
417 20th Street North, Suite 1100
Birmingham, AL 35203

Questions?
Call Customer Service: 1-800-294-7780
Monday - Friday, 8 a.m. - 5 p.m.

VIVA HEALTH does not participate in any discriminatory practices. For more information, visit www.vivahealth.com.