



MEMBER REIMBURSEMENT REQUEST FORM

**PLEASE PRINT OR TYPE**

Member 's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Member's Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_ Zip Code: \_\_\_\_\_  
Home Telephone: \_\_\_\_\_  
Member ID # (listed on you Member ID card): \_\_\_\_\_  
Date(s) of Service/Purchase: \_\_\_\_\_  
Amount Paid \_\_\_\_\_  
Provider Name (If Applicable): \_\_\_\_\_

Below please explain your Reimbursement request, please include any information you feel should be considered in the review of your request. Use additional sheet(s) if necessary. Please attach any document(s) that you feel should be reviewed. Complete, sign, and mail this request back to the address listed on this form. You can also fax it to the number listed on this form.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**REQUEST FOR REVIEW**

I HEREBY request a review of the Reimbursement request described above and understand that the receipt of this Reimbursement request by Solis constitutes a request for review. I understand that for SOLIS to review my reimbursement request, Solis may need medical or other records or information relevant to my request. Accordingly, I authorize persons or entities that have any medical or other records or knowledge of me to release such information to Solis for Solis to complete its review of my request. This information will not be released to any other organization or individual except as permitted under Federal and State Law, pursuant to court orders or subpoenas. Solis has established appropriate safeguards to ensure the privacy and confidentiality of all medical information and to prevent unauthorized access to it.

Member (or Authorized Representative\*)  
Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
If you are the authorized representative, you must sign above and provide the following information:  
Name: \_\_\_\_\_  
Relationship to Member: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Phone Number: \_\_\_\_\_

\*Authorized representatives must attach a copy of the “Appointment of Representative” (AOR) Form or other appropriate legal documentation supporting the authorized representative status. Examples of appropriate legal documentation include a Durable Power of Attorney for Health Care Decisions, a Health Care Surrogate, etc. You may request the “Appointment of Representative” form from our Member Services department. This form is also available on the Medicare website at [www.cms.gov/cmsforms/downloads/cms1696.pdf](http://www.cms.gov/cmsforms/downloads/cms1696.pdf) or on the SOLIS website at [www.SOLIShealthplans.com](http://www.SOLIShealthplans.com). The “Appointment of Representative” form must be signed by you and by the person you would like to act on your behalf. A copy of this form must be submitted to the plan.

Please mail or fax this signed form to:

Solis Health Plans  
PO Box 524173  
Miami, FL 33152  
Attn: Grievance/Appeals department  
Fax: 1-833-615-9263

Please note that your benefits will continue during this grievance/appeal if you remain enrolled in Solis. If you need assistance completing this form or any questions regarding it, please call Member Services at 1-844-447-6547, TTY 711, from 8 a.m. to 8 p.m. seven days a week from Oct. 1 – March 31 and 8 a.m. to 8 p.m. Monday-Friday from April 1 - Sept. 30.

**Solis Use Only**

Received by: \_\_\_\_\_

Date received: \_\_\_\_\_

By Mail

Time received: \_\_\_\_\_

By Fax

By Telephone

In Person

Other \_\_\_\_\_

**ATENCIÓN:** Si usted habla español, están disponibles para usted, y sin cargo, servicios de asistencia lingüística. Llame al 1-844-447-6547, TTY 711, de 8 a.m. a 8 p.m., los siete días a la semana desde el 1 de octubre hasta el 31 de marzo y de 8 a.m. a 8 p.m., de lunes a viernes desde el 1 de abril hasta el 30 de septiembre.

Solis is an HMO plan with a Medicare contract. Enrollment in Solis depends on contract renewal.