MISSIONARY MEDICAL PROGRAM REIMBURSEMENT FORM

FOR APPROVED HEALTHCARE EXPENSES IN THE UNITED STATES

PATIENT INFORMATION

Name:_____ Birth date: _____

MM ID number: _____ Cellphone:_____ Email: _____

Address: _____

EXPENSES FOR REIMBURSEMENT

Payments from the Missionary Medical Program are gratuitous, charitable, and made by Missionary Medical – a department of Deseret Mutual Benefit Administrators (DMBA) – on behalf of The Church of Jesus Christ of Latter-day Saints (the Church). To be reimbursed for approved healthcare expenses incurred in the United States that were billed to you by the provider instead of being sent to Missionary Medical, please provide the requested information:

- Include an itemized bill from the service provider including the patient's name, provider name, date services were received, total amount claimed, and a detailed description of the product or service. On the bill, write the document number related to the itemization in the table below. Be sure to include proof of payment made to the provider.
- If you have insurance, include a copy of the Explanation of Benefits (EOB) from your insurance or other third-party payer. List the amount paid by insurance below and write the associated document number on the EOB before you send it. If you have no insurance, please indicate N/A in the *Amount Paid by Insurance* column.
- Reimbursement is based on the care being approved and medical necessity. Reimbursement is subject to the allowable amounts determined by Missionary Medical. It is in your best interest financially to receive care from network providers. Network providers will generally bill Missionary Medical directly and accept what is paid as payment in full. If you use out-of-network providers, you are not reimbursed for amounts that exceed our allowable amounts. Also, you will not be reimbursed for expenses that are ineligible or covered by the Missionary Medical Program.
- Reimbursement rates are based on estimates provided through the DMBA and UHC provider networks or EOBs provided by your insurance. Any balance over the allowable amount is the patient's responsibility and will not be reimbursed by the plan.

Document Number	Service Date	Provider Name	Description of Service Provided	Amount Paid by Insurance	Amount Paid
1					
2					
3					
4					
5					
			Totals		

CERTIFICATION

I certify these expenses are in relation to the patient and I am requesting reimbursement for qualifying expenses. I understand reimbursement will be provided according to Missionary Medical Program guidelines and limitations.

Patient signature: _____ Date: _____

PLEASE NOTE: If any information or documents are missing or incorrect, we cannot reimburse you until we receive the proper documentation. To avoid future problems, ask your providers to bill Missionary Medical directly and provide them with the patient's billing information listed below.

Please return this completed form and attachments to Missionary Medical, Attn: CCS Team, P.O. Box 45730, Salt Lake City, UT 84145-0730, or email it to missionarymedical@dmba.com. For questions, call Missionary Medical at 801-578-5650 or 800-777-1647, or email us at missionarymedical@dmba.com.