Contraceptive Management Mobile Application Reimbursement Form

This form is to be used only for the reimbursement of Federal Drug Administration (FDA) approved mobile application(s) downloaded for contraceptive management, in accordance with federal regulations.

You can use this form to request reimbursement for the purchase of the application which has been authorized by the FDA.

- This form is for the FDA Authorized contraceptive management application purchased by you for monthly or annual reimbursement.
- Print your responses in black or blue ink.
- Include proof of payment (such as a paid receipt) that includes the name of the application along with this completed form. If we don't receive the required information, your request will not be processed.
- Send the completed form and proof of payment to the address on the back of your health plan ID card.

Subscriber/policyholder information

Policyholder/Member full name _____

Member ID _____ Plan/group # _____

Date of birth ___/___/_____ (MM DD YYYY)

Street address _____

City _____ State _____ ZIP _____

Is this a new address? ◯ Yes ◯ No

Phone number ___-___-_____ Email address _____

Patient name _____ Patient date of birth ___/___/_____ (MM DD YYYY)

Information about your application purchase

Is this reimbursement for the monthly fee or annual fee? _____

Purchase date(s) ___/___/_____ (MM DD YYYY) ___/___/_____ (MM DD YYYY) ___/___/_____ (MM DD YYYY)

Total amount submitted for reimbursement $ _____

(continued)

Member signature

Signature _____ Date ___/___/___
MM DD YYYY

When I sign above, I am stating that the information on this form is correct. Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete, or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

Ready to send the completed form?

Please send the completed form and proof of payment to the address on the back of your health plan ID card.

Before you submit this form, make sure you:

- Have completed and signed the form
- Have included proof of payment, such as a paid receipt
- Keep a copy of everything you send us

Questions? We're here to help.

If you have any questions, please call the member phone number on your health plan ID card.

*****STOP HERE*****

For Internal Use Only:
Diagnosis code: Z30.8
Place of Service: 10
HCPCS Code: A9293
Tax ID - 999999993
Units: 1

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