CareFirst

# REIMBURSEMENT RETURN FORM

## Account Holder Information (please print)

Last Name | First Name | Middle Initial

Street Address

City | State | Zip

Email address

## Spending Account ID #

S A

## Social Security # (if SA# is not known)

## Daytime Phone

## Returned Reimbursement Details

**Returned Amount: $** _____

**Original Payment was:**

☐ Further Check or ACH:

Original Check or ACH Date: _____ Original Check or ACH Amount: _____

☐ Debit Card Purchase: Purchase Date: _____ Debit Card purchase paid from: ☐ FSA ☐ HRA ☐ HSA ☐ VEBA

**Returned Payment by:**

☐ Returning Further Check

☐ Returning Provider Check: Provider Name: _____ Provider Phone #: _____

☐ Personal Check # _____

☐ Use existing bank account on file at Further. Verify bank account number: _____

To add new banking information, login to the Online Member Portal at carefirst.com/myaccount.

## Reimbursement Return Reason

☐ Health plan adjusted the patient responsibility causing an overpayment from Further.

Dates of Service:_____

☐ Debit Card Purchase Returned

☐ Other:_____

**Please attach a copy of the Explanation of Processing received with the reimbursement being returned.**

## Signature

To my knowledge, all information provided above is complete and accurate.

_____ _____

Account Holder | Date

Questions? Call Member Services at 1-866-758-6119.

**Send via secured email only:**
CareFirstDocuments@hellofurther.com

**Fax to:**
866-231-0214

**Mail to:**
**Further c/o CareFirst**
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St. Paul, MN 55164-0193