Annual Billing Summary Statement Request Form

Instructions:

You must use this form to request information about your total premium payments paid to L.A. Care during the benefit year that you were covered. Please complete and sign this form. If you have any questions, please call L.A. Care Member Services at **1-855-270-2327** (TTY **711**). L.A. Care representatives are available 24 hours a day, 7 days a week.

Subscriber/Responsible Party Information

Benefit Year Requested:	**Health Plan Name (Please check one box)**: ☐ **L.A. Care Covered™** ☐ **L.A. Care Covered *Direct*™**		
Name (Last, First)			
Date of birth (month/day/year)	Member ID #		
Physical Address (including apt number)	City	State	ZIP Code
Mailing Address (if different from above)	City	State	ZIP Code
Day Time Phone # / Evening Phone #	Email Address		

Return Signed Form to:

Mail: L.A. Care Health Plan Attn: Medical Payments Systems and Services 1055 W 7th Street, 10th Floor Los Angeles, CA 90017	**Fax:** L.A. Care Health Plan Attn: Medical Payments Systems and Services Re: "Annual Billing Summary Statement Request Form" (213) 438-6105

Delivery Method for Your Annual Billing Summary Statement

☐ **United States Postal Service** I authorize L.A. Care Health Plan to send me a copy of my Annual Billing Summary Statement via U.S. Postal Services to the mailing address listed above.

☐ **Secure Email** I authorize L.A. Care Health Plan to send me a copy of my Annual Billing Summary Statement via secure email to the email address listed above.

Authorization *(required)*

I hereby authorize L.A. Care Health Plan to provide me a copy of my Annual Billing Summary Statement which confirms the premium paid to L.A Care for the Benefit Year indicated above.

Name _____ Signature _____ Date _____