MEMBER REIMBURSEMENT FORM

Please complete all information requested. An incomplete form may either delay your reimbursement or may be returned for additional information. Reimbursement is not guaranteed. Claims will be reviewed, subject to limitations, exclusions and other provisions of the Plan benefit. **Please note that all reimbursement checks will be made out to the Subscriber.**

Date Submitted: _____Member Name: _____

Date of Birth: _____ Member ID: _____

Phone Number: _____ Social Security Number: _____

Date(s) of Service_____ Reimbursement Amount_____

Provider/Facility Name:

_____

Provider/Facility Address:

_____

1.) Was this service an emergency? Please briefly describe the incident.
2.) Was this service an elective procedure?

- Please attach a copy of your receipt, claim and an itemized medical statement.
- We may contact you or your Provider if additional information is required.

Method of Check Reimbursement:

All Checks will be mailed to the address on file with Preferred Administrators
**If your address has changed, please reach out to your HR Department to update your address **

Signature: _____ Date: _____

Mail or fax form to: Preferred Administrators
P.O. Box 971370
El Paso, TX 79997-1370
Fax# 915-225-1174

If you have any questions, please contact Preferred Administrators at 915-532-3778 ext. 1529.

For Administrative Use Only

Signature: _____ Date: _____

Approved: ☐ Denied: ☐ Approved Reimbursement Amount: $ _____

Notes:

100PA706807172025