



**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 Member.**

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: \_\_\_\_\_

**If reimbursement request is for a breast pump, please check here  and skip questions 1 and 2 below.**

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 or claim and an itemized medical statement for services rendered.
- We may contact you or your Provider if additional information is required.

**Method of Check Reimbursement**

- Check box if you want check mailed:
- Check box if you want to pick up at Preferred Administrators

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Mail or fax form to: Preferred Administrators  
P.O. Box 971370  
El Paso, TX 79997-1370  
Fax# 915-298-7863

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: