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 Policy Holder.**

Date Submitted: _____ Policy Holder Name: _____

Member Name: _____ Member ID: _____

Phone Number: _____ Social Security Number: _____

Date of Birth: _____ Date(s) of Service: _____

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 will contact you or your Provider if additional information is required.
- You will receive a phone call from our TPA Department telling you whether your claim was paid or denied within a week of receipt of your claim form.

Signature: _____ Date: _____

Mail or fax form to: Preferred Administrators- TPA Department
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.

For Administrative Use Only

Signature: _____ Date: _____

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

Notes: