CLAIM REIMBURSEMENT **FORM**

Please complete the form below and attach all bills pertaining to this specific claim only. Use a separate claim form for each dependent. Send this form and all attachments through one of the methods listed below:

If sending by mail, mail to:
Assured Benefits Administrators
P.O. Box 211517
Eagan, MN 55121-2717

If sending by facsimile, fax to:
915-532-1772

If you have any questions, contact us at 1-866-231-5589. Our customer service representatives are available Monday through Friday from 8 a.m. to 6 p.m. Central Standard Time.

EMPLOYEE NAME ____ EMPLOYER ____

MEMBER ID ____ PHONE ____ EMAIL ____

ADDRESS ____ CITY ____ STATE ____ ZIP ____

CLAIM IS FOR: ☐ EMPLOYEE ☐ SPOUSE ☐ CHILD CLAIMANT'S DATE OF BIRTH ____

DOES THE CLAIMANT HAVE OTHER HEALTH INSURANCE COVERAGE? ☐ YES ☐ NO

If ***YES***, OTHER INSURANCE CARRIER ____ ELIGIBILITY DATES ____

REASON CLAIM IS BEING FILED: ☐ ACCIDENT ☐ MATERNITY ☐ NEWBORN ☐ WELL PATIENT ☐ DENTAL ☐ VISION

If ***ILLNESS***, DATE SYMPTOMS FIRST APPEARED ____ DATE PHYSICIAN FIRST CONSULTED ____

If ***ACCIDENT***, GIVE DETAILS ____

I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO THE PROVIDER OF THESE SERVICES. ☐ YES ☐ NO

SIGNATURE ____ PRINT NAME ____

DATE ____

REMINDER: PLEASE ATTACH ALL RECEIPTS.