INCENTIVE REQUEST FORM

ASEA Health Benefits Trust

Address: PO Box 5434, Spokane, WA 99205 • Phone: 866-553-8206 (toll-free); 509-328-0300
Fax: 509-328-8623 • Website: www.aseahealth.org

The ASEA Health Trust has negotiated rates at Alaska Regional Hospital that are much lower than Mat-Su Regional Hospital rates. Therefore, the Trust will pay an incentive to participants who live in the Mat-Su Borough and choose to receive treatment at Alaska Regional Hospital instead of Mat-Su Regional Hospital.

The incentive amount will be 10% of the amount the Trust pays Alaska Regional Hospital, up to $500 for outpatient services and $1,000 for inpatient services. The incentive:

- Applies to scheduled inpatient services or outpatient procedures/surgery only
- Applies to each treatment episode (each period of hospitalization and each day of outpatient surgery, from facility admittance to check out, is considered one treatment episode)
- Is based on facility fees only
- Is only available when the Health Trust Health Plan is the patient's primary plan
- Requires the participant to complete the Incentive Request form and submit it within 365 days of the date of service.
- This incentive may be considered taxable income. Please consult with your tax advisor.

1. Complete Sections 1–4
2. Submit the following documentation with the request:
   • Explanation of Benefits for the Alaska Regional Hospital claim
3. If you have questions about the Incentive Benefit, call the ASEA Health Trust Administrator at the number above.
4. Send the completed Incentive Request Form and documentation to the ASEA Health Trust Administrator at the address above.

1. EMPLOYEE INFORMATION

Employee name: SSN or Health Plan ID:

Address (at time of service):

City/State/Zip

2. PATIENT INFORMATION

Name: Date of birth:

Relationship to employee: ❑ Self ❑ Spouse ❑ Same-sex partner ❑ Child

3. DATE OF SERVICE

Date of service:

Employee signature: Date:

4. CERTIFICATION

I certify that my primary residence is in the Mat-Su Borough and I reside in the Mat-Su Borough. I certify that the information on this claim is correct and the services were provided as indicated. I also authorize the release of medical records to the ASEA Health Trust Administrator for the purposes of determining my benefits payable under the provisions of this Plan or any other Plan. I understand that any person who knowingly and with intent to defraud or deceive any health plan, files a statement of claim containing any materially false, incomplete, or misleading information is guilty of a crime and may be liable for substantial civil penalties.

Employee signature: Date: