

REQUEST FOR REIMBURSEMENT—MEDICAL/DENTAL BENEFITS

ASEA Health Trust

Address: 111 W. Cataldo, Suite 220, Spokane, WA 99201 • Phone: 866-553-8206 (toll-free); 509-328-0300 • Fax: 509-328-8623

Website: www.aseahealth.org

Use this form, as directed by the ASEA Health Trust Administrator, to provide detailed information about a claim that has been submitted for payment.

PLEASE PRINT CLEARLY

Employee name: _____ SSN or Alternate ID: _____

Address: _____ Phone number: _____

City/State/Zip: _____ Sex: M F

Patient name: _____ Date of birth: _____ Relationship: _____

If the patient is a dependent, is the dependent employed? Yes No

Is the patient covered by any other health insurance (for example, Native Health or Medicaid benefits)? Yes No

If yes, complete the Other Coverage Information section below.

OTHER COVERAGE INFORMATION (Complete if participants are covered by more than one plan, including Medical, Dental or Vision)

Insurance company name: _____ Active Retiree

Plan number: _____ Effective Date: _____ Phone number: _____

Address: _____ City/State/Zip: _____

Which family member is the Primary insured? _____ Date of birth: _____

SSN or Alternate ID: _____ Group number: _____ Group Name: _____

Who is covered by this policy? _____

Is this claim due to a work-related accident, injury or illness? Yes No If yes, please complete the following information:

Date of accident, illness or injury: _____ Time: AM PM

Describe how and where the accident, injury or illness occurred.

CERTIFICATION AND RELEASE OF INFORMATION

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.

Employee signature: _____ Date: _____

Patient signature (if of legal age): _____ Date: _____

AUTHORIZATION TO PAY PHYSICIAN OR SUPPLIER OF SERVICE

I hereby authorize payment to be made directly to the physician or supplier of service shown on the attached itemized statement.

Employee signature: _____ Date: _____

Note: The ASEA Health Trust Administrator provides claims payments service, but does not insure benefits.