REQUEST FOR REIMBURSEMENT—MEDICAL BENEFITS

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

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 medical plan.)

Insurance company name: ❑ Active ❑ Retiree

Policyholder's name: Effective date: Phone number:

Address: City/State/Zip:

SSN or Alternate ID: Date of birth: Group number:

Family members covered by this Plan:

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.