



## Claim reimbursement form

### A. Subscriber and member information

We only reimburse covered services, procedures, and diagnoses. To see what's covered, search for your plan on [selecthealth.org/plan-documents](http://selecthealth.org/plan-documents) or call Member Services at **800-538-5038**.

Subscriber ID # (found on your Select Health ID card) \_\_\_\_\_

Patient's name \_\_\_\_\_ Patient's date of birth Month / Day / Year \_\_\_\_\_

Patient's phone number ( \_\_\_\_\_ ) \_\_\_\_\_ Relationship to subscriber  Self  Spouse  Dependent

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

### B. Other insurance information

Does the patient have other insurance besides Select Health?  Yes  No

If yes, please complete the following:

Insurance company \_\_\_\_\_ Is this the patient's primary insurance?  Yes  No

Other insurance company policy ID number \_\_\_\_\_

Policyholder's name \_\_\_\_\_ Date of birth Month / Day / Year \_\_\_\_\_

Policyholder's relationship to patient \_\_\_\_\_

### C. Claim information

Provider or facility \_\_\_\_\_ Provider or facility tax ID \_\_\_\_\_ (If available)

National provider ID (NPI) \_\_\_\_\_ (If available) Provider phone number ( \_\_\_\_\_ ) \_\_\_\_\_

Provider or facility address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Mailing address (if different) \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Date(s) of service Month / Day / Year \_\_\_\_\_ | Month / Day / Year \_\_\_\_\_ | Month / Day / Year \_\_\_\_\_ | Month / Day / Year \_\_\_\_\_

Billed amount \$ \_\_\_\_\_

Description of services \_\_\_\_\_

Procedure code(s) \_\_\_\_\_ Diagnosis code (medical only) \_\_\_\_\_

### D. Accident information

Were the services related to an accident?  Yes  No

Date of accident Month / Day / Year \_\_\_\_\_

Where did the accident occur?  Work  Auto  School  Other

Description of the injury \_\_\_\_\_

**Note:** Your claim reimbursement may not be processed without a procedure and diagnosis code.

Tooth number and surface letter (dental only) \_\_\_\_\_

## E. Foreign claims

Were the services rendered outside of the United States, United States Territories or aboard a cruise ship?

Yes  No

Any reimbursement request over \$25,000.00 requires medical records and an itemized statement.

Is there a travelers insurance policy?  Yes  No

Traveler insurance name \_\_\_\_\_

Traveler insurance policy ID number \_\_\_\_\_

## F. Required information for reimbursement

Proof of payment is required for reimbursement:

Credit card statement  Bank statement  Paid invoice statement

## Reimbursement form instructions

To ensure that your benefits are administered correctly and without delay, complete all of the information on this form. Enclose a copy of your receipt with this form. If you are submitting multiple receipts, one reimbursement form is required for each receipt. Once you've completed this form, upload it to [selecthealth.org/claims](https://selecthealth.org/claims).

If preferred, you can also send it by fax or mail to:

### Mail

**Select Health**  
**P.O. Box 30192**  
**Salt Lake City, Utah**  
**84130-0192**

### Fax

**801-442-0204**

Claims submitted without the proper identification numbers may be delayed or returned for additional information. If you have questions, call Member Services at **800-538-5038** weekdays, from 7 a.m. to 8 p.m., and Saturday, from 9 a.m. to 2 p.m. TTY users, please call **711**.

Select Health obeys federal civil rights laws. We do not treat you differently because of your race, color, ethnic background or where you come from, age, disability, sex, religion, creed, language, social class, sexual orientation, gender identity or expression, and/or veteran status.

This information is available for free in other languages and alternate formats by contacting Select Health Medicare:

**855-442-9900** (TTY: **711**) / Select Health FEHB: **844-345-FEHB (3342)** / Select Health: **800-538-5038**.

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística.

注意:如果您使用繁體中文,您可以免費獲得語言援助服務。請致電