

PAY MY PROVIDER

Request Form

COMPANY NAME

(PLEASE PRINT)

EMPLOYEE INFORMATION

SSN			DOB	
Last Name	First Name			MI
Address				
City	State			Zip Code
Day Phone #				Email

PROVIDER INFORMATION

(REQUIRED - MUST COMPLETE ALL SECTIONS - LACK OF PROVIDER INFORMATION WILL RESULT IN DENIAL OF CLAIM.)

Tax Identification Number (TIN)				
Provider Name				
Address				
City	State			Zip Code
Phone #				

TRANSACTION INFORMATION

Patient Name	Date of Service (MM/DD/YY)
Type of Service: <input type="checkbox"/> Office Visit <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Ortho <input type="checkbox"/> Copay <input type="checkbox"/> Chiro <input type="checkbox"/> Hospital <input type="checkbox"/> Lab <input type="checkbox"/> X-ray <input type="checkbox"/> Therapy <input type="checkbox"/> Other: _____	
Brief description of service: _____	
You must attach appropriate proof of service for amount requested. Acceptable documentation generally includes a statement or invoice from provider listing: date of service, description of service and amount due. Balance forward statements are not accepted. Failure to submit appropriate documentation will result in denial of request for payment.	Total Amount \$

CERTIFICATION

(REQUEST CANNOT BE PROCESSED WITHOUT YOUR SIGNATURE)

I certify that the expense listed above qualifies for reimbursement and has been incurred by me or by eligible members of my family. This expense has not been reimbursed by any other plan(s). I further certify that if the above expense is not eligible, I will remit payment in the amount of the ineligible expense to the Plan. Additionally, this expense is not being claimed as tax deductions under IRS code. Bills, statements or other proof of the expense is attached:

Participant Signature

Date