

Amwell Claim Form



STAR Plan Members: Use this form to have your Amwell co-payment credited toward your deductible and limits.

560 East 200 South, Salt Lake City, UT 84102
801-366-7555 / 800-765-7347
Fax: 801-366-7771

» Please attach your Amwell receipt

» Requested Credit Amount

\$

» Cardholder Information *See your PEHP Member ID card.*

Member ID _____

Member Name _____

Street Address _____

City _____ State _____ Zip _____

» Patient Information

Patient Name _____

Patient Date of Birth (Month/Day/Year) _____

Sex

Relationship to Plan Member

Female

1 Self

5 Disabled Dependent

Male

2 Spouse

6 Dependent Parent

3 Eligible Child

7 Non-spouse Partner

4 Dependent Student

8 Other