Direct Primary Care Services (DPC)
Subscription Reimbursement Form

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

A Direct Primary Care Provider charges a monthly fee for all of your primary care needs. While DPCs do not contract with insurance companies, PEHP helps you pay for your DPC monthly fee by submitting this form.

Reimbursement Eligibility

» You must have primary coverage with PEHP that includes out-of-network benefits.

» Fees must cover at least a 3-month period. DPC services for less than a 3-month period will not be reimbursed. If you cancel your DPC membership after three months (e.g., in the fifth month), you can request reimbursement from PEHP for the remaining two months.

» You must not have received primary care services from another provider during the period for which you are seeking reimbursement.

Reimbursement Amounts

PEHP reimburses the lesser of the paid amount or a flat fee allowed amount of $38.67 per month for adults and $19.12 per month for children (ages 2-18), regardless of your actual payment.

» Instructions

Complete this form and return it to us with the following:

» A copy of your payment receipt from the DPC provider that shows your member payment, subscription dates, and patient subscription details.

Proof of Payment Examples:

› Copy of cashed check, credit/debit card statement

› Detailed ledger showing charges with dates and payments with dates

Send via the secure Message Center to "Customer Service" or mail to us at the address on the top right.

» Requested Amount

$ _____

☐ I attest that I only received primary care services from my Direct Primary Care provider for the 3-month period covering my reimbursement request.

» Policy Holder Information *See your PEHP Member ID card.*

Member ID _____

Member Name _____

Street Address _____

City _____ State _____ Zip _____

Direct Deposit Bank Information

(Applies only if your PEHP ID number starts with "M000" and you've already met your plan deductible and out-of-pocket maximum.)

Bank Routing Number _____ Account Type: ☐ Checking ☐ Savings

Bank/Credit Union Name _____ Account Number _____

» Patient Information

Patient Name _____

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

Sex

☐ Female
☐ Male

Relationship to Plan Member

☐ 1 Self
☐ 2 Spouse
☐ 3 Eligible Child
☐ 4 Dependent Student
☐ 5 Disabled Dependent
☐ 6 Dependent Parent
☐ 7 Non-spouse Partner
☐ 8 Other