### **Medical & Dental Claim Credit/Reimbursement**

Use this form to get credit and/or reimbursement after you have paid a provider directly for a covered benefit.



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

# » Instructions

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

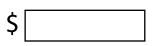
- » A receipt that shows provider information and codes for applicable services rendered or equipment received. Providers can produce this information on the HCFA 1500 or Hospital UB claims form.
- » A copy of your payment receipt to the provider that shows the codes and costs paid.

#### **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 <u>Message Center</u> to "Customer Service" or mail to us at the address on the top right.

## >> Requested Amount



Note: COVID tests are reimbursed only when ruling out exposure, not when given to healthy individuals for travel or employment reasons.

I agree my COVID test was for confirming sickness.

### >> Policy Holder Information See your PEHP Member ID card.

Member ID _			
Member Nam	ne		
Street Addres	SS		
City		State Zip	
•	<b>sit Bank Information</b> Ir PEHP ID number starts with "M000" and you	ı've already met your plan deductible and out	t-of-pocket maximum.)
Bank Routing Number		Account Type: 🔲 Chec	king 🔲 Savings
Bank/Credit Union Name		Account Number	
» Patient l	nformation		
Patient Name	2		
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	MCR-ACH 12/5/23