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.

PEHP Health & Benefits
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 Message Center 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 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