Medical Claim Reimbursement

Only use this form when you have paid a provider for a claim and are seeking reimbursement for your costs.

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

Important, Please Read

Form Instructions

Use the form on the next page when you have paid a medical provider for a claim and are seeking reimbursement for your costs.

Include the following information:

» PEHP Request form

» HCFA 1500 or UB hospital claim form

» Receipt showing payment for services

Please call PEHP Customer service at 801-366-7555 or 800-765-7347 to receive an encrypted email. If you prefer to mail or fax your request, please see the request form for PEHP's mailing address and/or fax number.

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» Instructions for Reimbursement

Please attach:

- » Itemized HCFA 1500 form
- » UB hospital claim form
- » Receipt showing payment for service rendered

» Requested Reimbursement 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

- ☐ 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