ADVANTAGE
HEALTH PLANS TRUST

MEMBER REIMBURSEMENT / SELF-PAY CLAIM FORM

All fields MUST be completed for reimbursement to be processed.

Member Details

Member Name (first, middle, last):

Address (Street Address, City, State, Zip Code):

Telephone (with area code):

Date of Birth:

Member ID #:

Soc Sec Number:

Email:

Dependent Information (Fill out the information below *only* if this claim is on a dependent)

Dependent Name:

Relationship to Member:

Address:

Date of Birth:

Telephone:

Email:

NOTE: If this claim is on a dependent who is 18 years of age or older, the dependent must submit a HIPAA PHI Release Form available at advantagehealthplans.com. Advantage Health Plans Trust may not speak with the member regarding claim details without this form.

Claim Details

Provider Name: Dusty L. Nielsen D.C.

Provider Phone: 580-256-3122

Provider NPI: 1184801623

Providers Tax ID:

Provider's Address: 1502 Oklahoma Ave, Woodward, OK 738501

CPT Code(s)

Diagnosis Code(s):

Reason for Visit and Description of Services:

Amount Paid:

Date(s) of Service:

Instructions:

All fields MUST be completed to process reimbursement. Claims must be filed timely, per the terms of the Plan, to be considered for reimbursement. Please send the information indicated below to Advantage Health Plans Trust via email to **customerservice@kemptongroup.com** or via **fax to (405) 521-9804**.

Required Information:

1. Member Reimbursement / Self-Pay Claim Form.
2. HCFA, claim form, or other provider documentation that must include diagnosis codes, CPT codes, description of services, date of service, and total charges.
3. Payment Receipt.

Signature

The information provided is truthful and accurate to the best of my knowledge. I understand that if claims were for non-covered or excluded services under the Plan, I will not be reimbursed. I understand that if claims were incurred due to third party liability or performing work for which I have been compensated, the Plan has the right to recover any payments made by the Plan. Please see your Summary Plan Description for more information.

Printed Patient Name:

Printed Member Name:

Signature:

Date: