MEMBER REIMBURSEMENT / SELF-PAY CLAIM FORM

Member Details

Member Name (first, middle, last):

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

Telephone (with area code):

Date of Birth:

Member ID #:

Social Security Number:

Email:

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

Dependent Name:

Relationship to Member:

Address:

Date of Birth:

Telephone:

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. The Kempton Company may not speak with the member regarding claim details without this form.

Claim Details

Provider Name:

Provider's Telephone:

Providers Tax ID:

Provider's Address:

Reason for Visit:

Paid Amount:

Description of Services:

Instructions:

Please send the information indicated below to Advantage Health Plans Trust via email to customerservice@kemptongroup.com or via fax to (405) 608-5831. Claims must be filed timely, per the terms of the Plan, to be considered for reimbursement.

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.

Member Printed Name:

Signature of ***Member:***

Date:

Signature of ***Patient:***

Date:

(Only if patient is age 18 or over)