

BridgeSpan Health Company 2890 E. Cottonwood Parkway Salt Lake City, UT 84121-7089

DIRECT MEMBER REIMBURSEMENT FORM

Thank you for choosing us for your health insurance coverage. Use this claim form for any reimbursement requests you may have. If you received services from a participating provider, your claim should be submitted by the provider; therefore, you do not need to submit this form unless you know that your claim was not submitted. Please complete a separate form for each family member, pharmacy or provider (print additional copies of page 2 if necessary). For claim filing time limits, review your benefit information.

- 1. Complete the information below and where indicated on the following page.
- 2. Write your ID number on the top of each page.
- 3. Tape your original receipts in the boxes marked for receipts; cash register receipts will not be accepted.
- 4. Retain copies of receipts for your records. Receipts will not be returned.
- 5. Sign the completed form where indicated at the bottom of this page and mail to: BridgeSpan Health Company
 - PO Box 1106

Lewiston, Idaho 83501

MEMBER INFORMATION						
Patient's Name (Last, First, M.I.)		Patient's Da	Patient's Date of Birth			Patient's Sex
						Male Female
Policyholder's Name (Last, First, M.I.)					Relationship to Policyholder	
					Self	Spouse Dependent
Policyholder's Street Address	City		State	ZIP Code		Telephone Number
Patient's ID Number		Group Nam	Group Name		Group Number	
OTHER INSURANCE INFORMATION						
Are you or ANY family members on this policy covered by other:						
Prescription Coverage? Yes No						
If YES, is this coverage Group Individual						
Are you or any family members covered by Medicare? Yes No If YES: Part A Part B Part D						
IF THE ANSWER TO ANY OF THE ABOVE QUESTIONS IS "YES," please complete the section regarding the other insurance.						
If there are more than one additional policy, attach the requested information for each policy on a separate sheet of paper.						
Name of Other Insurance Subscriber's	Name	ID Number		[Date of Birth	Subscriber's Relationship to BridgeSpan Policyholder
						BrugeSpan Policyholder
Street Address for Submitting Claims		City	/	_		State ZIP Code
This other insurance covers: If covered children are from divorced parents, indicate name of person with legal cust						name of person with legal custody
BridgeSpan Policyholder's Spouse BridgeSpan Policyholder Dependents						
Name of Subscriber's Employer				Active 🔲 R	E	ffective Date of this Plan
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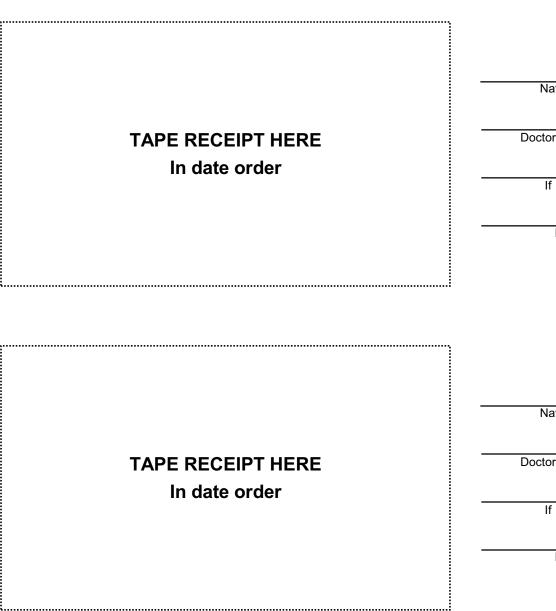
Please indicate why the patient paid in cash___

I certify that the above statements are correct and hereby authorize any physician, dentist, hospital, employer, union, insurance company, or prepayment organization to supply my employer and its agents any information required in connection with this claim. A photocopy of this authorization shall be as valid as the original.

Signature (Subscriber or Patient)

Prescription (Rx) receipts must contain: Rx Number Date Rx was filled Provider's Name Drug Name and NDC Number Quantity and days supply Charge Medical, Dental and Vision receipts must contain: Provider's Name and Address National Provider Identifier Diagnosis and Procedure Codes Date of Service Itemized Charges

Contact the provider or pharmacy if you need additional information



Nature of Illness or Injury

Doctor's Name (If not on receipt)

If Injury, Date Occurred

How, When, Where

Nature of Illness or Injury

Doctor's Name (If not on receipt)

If Injury, Date Occurred

How, When, Where