

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 Date of Birth				Patient's Sex			
							M M	ale 🗌 Female	
Policyholder's Name (Last, First, M.I.)		I			Patient's	s Relat	tionship to	Policyholder	
					Sel:	f 🗌	Spouse	Dependent	
Policyholder's Street Address	City	State ZIP Code		ZIP Code		Telephone Number		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:									
Medical coverage? Yes No Vision Coverage? Yes No									
Dental coverage? Yes No With Orthodontia? Yes No									
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				ate of Birth Subscriber's Relationship		r's Relationship to	
						BridgeSpan Policyholde			
Street Address for Submitting Claims		City	/				State	ZIP Code	
This other insurance covers:	If covered children	vered children are from divorced parents, indicate name of person with legal custody							
BridgeSpan Policyholder's Spouse BridgeSpan Policyholder Dependents									
Name of Subscriber's Employer		Effective Date of this Pla			this Plan				
		Active Retiree							
L									

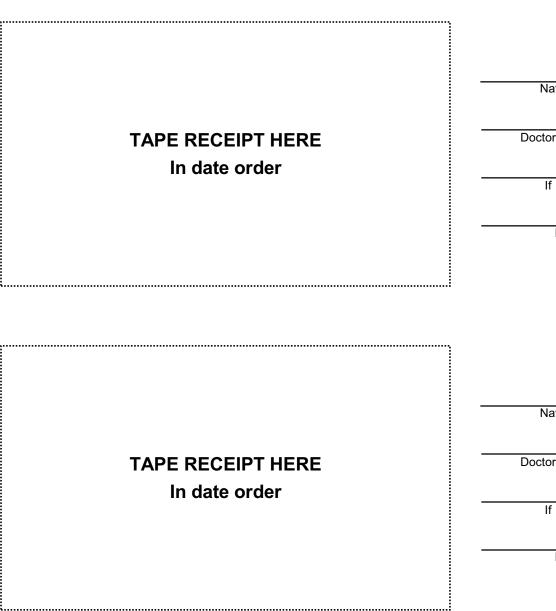
Please indicate why the patient paid in cash_

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