ASURIS NORTHWEST HEALTH

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:
   Asuris Northwest Health
   PO Box 1106
   Lewiston, Idaho 83501

MEMBER INFORMATION

Patient's Name (Last, First, M.I.)	Patient's Date of Birth (mm/dd/yyyy)	Patient's Sex ☐ Male ☐ Female
Policyholder's Name (Last, First, M.I.)		Patient's Relationship to Policyholder ☐ Self ☐ Spouse ☐ Dependent

Policyholder's Street Address	City	State	ZIP Code	Telephone Number
		State	xxxxx-xxxx	(xxx) xxx-xxxx

Patient's ID Number	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	Date of Birth (mm/dd/yyyy)	Subscriber's Relationship to Asuris Policyholder

Street Address for Submitting Claims	City	State	ZIP Code
		State	xxxxx-xxxx

This other insurance covers: ☐ Asuris Policyholder's Spouse ☐ Asuris Policyholder ☐ Dependents	If covered children are from divorced parents, indicate name of person with legal custody

Name of Subscriber's Employer	☐ Active ☐ Retiree	Effective Date of this Plan (mm/dd/yyyy)

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.

▶ _____ (mm/dd/yyyy)

Signature (Subscriber or Patient) Date

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

TAPE RECEIPT HERE
In date order

Nature of Illness or Injury

Doctor's Name (If not on receipt)

(mm/dd/yyyy)
If Injury, Date Occurred

How, When, Where

TAPE RECEIPT HERE
In date order

Nature of Illness or Injury

Doctor's Name (If not on receipt)

(mm/dd/yyyy)
If Injury, Date Occurred

How, When, Where