selecthealth.

P.O. Box 30192 Salt Lake City, UT 84130-0192 **800-538-5038** **selecthealth.org**

Claim Reimbursement Form

A. SUBSCRIBER AND MEMBER INFORMATION

Subscriber ID # (found on your SelectHealth ID Card) _____

Patient's Name _____ Patient's Date of Birth _____
(MM/DD/YY)

Relationship to Subscriber: ❑ Self ❑ Spouse ❑ Dependent

Address _____

City _____ State _____ Zip _____

B. OTHER INSURANCE INFORMATION

Does the patient have other insurance besides SelectHealth? ❑ Yes ❑ No

If yes, please complete the following:

Insurance Company _____ Is this the patient's primary insurance? ❑ Yes ❑ No

Other Insurance Company Policy ID # _____

Policyholder's Name _____ Date of Birth _____
(MM/DD/YY)

Policyholder's Relationship to Patient _____

C. CLAIM INFORMATION

Provider or Facility _____ Provider or Facility Tax ID _____

National Provider ID (NPI) _____ Provider Phone Number _____

Date of Service _____ Billed Amount $_____._____
(MM/DD/YY)

Description of Services _____

Procedure Code _____ Diagnosis Code (medical only) _____

D. RECEIPT

Tape one receipt in this space. Please do not use staples.

Reimbursement Form Instructions

To ensure that your benefits are administered correctly and without delay, complete all of the information on this form. Attach a copy of your receipt to this form. If you are submitting multiple receipts, one reimbursement form is required for each receipt. Submit claims to the address below:

SelectHealth
P.O. Box 30192
Salt Lake City, Utah 84130-0192

Claims submitted without the proper identification numbers may be delayed or returned for additional information. If you have questions, call Member Services at **800-538-5038** weekdays, from 7:00 a.m. to 8:00 p.m., and Saturdays, from 9:00 a.m. to 2:00 p.m. TTY users please call 711.