



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

# Claim Reimbursement Form

## A. SUBSCRIBER AND MEMBER INFORMATION

We only reimburse for covered services, procedures, and diagnoses. To find out if a service is covered, please call Member Services at **800-538-5038**.

Subscriber ID # (found on your SelectHealth ID Card) \_\_\_\_\_

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

Patient's Phone # \_\_\_\_\_

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 \_\_\_\_\_ *Required*

National Provider ID (NPI) \_\_\_\_\_ *Required* Provider Phone Number \_\_\_\_\_

Physical Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Mailing Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Date of Service \_\_\_\_\_ Billed Amount \$ \_\_\_\_\_ (MM/DD/YY)

Description of Services \_\_\_\_\_

Procedure Code \_\_\_\_\_ *Required* Diagnosis Code (medical only) \_\_\_\_\_ *Required*

**NOTE:** Your claim reimbursement may not be processed without a procedure and diagnosis code.

Tooth Number and Surface Letter (dental 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 Saturday, from 9:00 a.m. to 2:00 p.m. TTY users, please call 711.