NORTH AMERICAN DIVISION BENEFITS Healthcare

HealthSCOPE BENEFITS

CLAIMS REIMBURSEMENT REQUEST FORM

For all non-prescription claim employee reimbursements requests including medical, dental, or vision.

EMPLOYER INFORMATION

Employer:

EMPLOYEE/MEMBER INFORMATION (As on your benefit card)

Employee's Name: Member #:

Patient's Name: Patient's Birth Date:

Group #:

IMPORTANT:

- Failure to use the correct Reimbursement Request Form may cause delay in processing your claim.
- Be sure the patient information on the claim form is correct.
- Original bills from the provider of the healthcare service must be provided (per plan guidelines)
- Keep a copy of your receipt and this cover sheet for your records

ADDITIONAL INFORMATION

Indicate below any additional information that may be helpful in processing your request:

Mail this form with paper documentation to:

HealthSCOPE Benefits

Address:
P.O. Box 16203
Lubbock, TX 79490-6203

Fax
915-581-7537

(From Fate 01/09/2015)