



CLAIMS REIMBURSEMENT REQUEST FORM

ADVENTIST RISK MANAGEMENT, INC.

Providing Solutions to Minimize Risks

This form is to be used for the following services only.

Please Select One:

- LASIK**
 Acupuncture
 Adult Immunization
 Dental
 Vision
 Massage
 Chiropractic

Part 1

Employee's Name: _____

Employee's Member ID: _____

Patient's Name: _____

Patient's Birth Date: _____

Part 2

Employer's Name: _____

Employer's Group Number: _____

Pay Employee: _____

Pay Provider: _____

IMPORTANT

- ALL claims submitted must be on 8 ½ x 11 or copied to 8 ½ x 11 paper. **USE WHITE PAPER ONLY!**
- Be sure the patient information on the claim form is correct.
- Original bills from the provider of the healthcare service must be provided. If you cannot submit the original bills, please be sure your itemized receipt has the following information:
 1. Provider's name, address, and Federal Identification Number (also known as a TAX ID).
 2. Name of patient and name of employee.
 3. Employee's Member ID (see Healthcare ID card)
 4. Date of service, treatment or purchase;
 5. Type of treatment;
 6. Diagnosis;
 7. CPT code related to service provided;
 8. Each item or service for which you are charged; and
 9. Amount of charge. (Non-itemized receipts or billings are not acceptable).
- Make sure the copy you mail to Adventist Risk Management is legible and the print dark enough to scan properly.
- Please attach your receipts to this form.
- Keep a copy of your receipt for your records.

Mail This Form and Receipts to

Adventist Risk Management, Inc, PO Box 1021, Horsham, PA 19044-1021