



MEMBER REIMBURSEMENT FORM

Employee Information (to be completed by employee) Please Print Clearly

Please read instructions below before completing Claim Form

Employee Name: _____ Date of Birth: ____/____/____
Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Business Phone: _____
Member ID #: _____

Patient Information (if other than employee)

Patient Name: _____ Date of Birth: ____/____/____
Relationship: _____
Sex: Circle One – Male / Female

Other Benefits:

If SAS is the SECONDARY insurance, a copy of the primary Explanation of Benefits (EOB—the statement describing how your benefits were paid) is required from the other plan or Medicare for processing.

Employee Certification

I authorize the release of any information regarding this claim. I certify that the information provided by me is correct and that I have not been previously reimbursed for these services. I understand that any intentional failure to complete this claim form accurately may lead to disciplinary action.

*Employee's Signature: _____ Date: _____

14110 Airport Road • Suite 100 • Gulfport, MS 39503 • Ph (800) 847 – 6621
Ph (228) 865 – 0514 • Fax (228) 865 – 4759 or (800) 796 – 8834

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Employee Instructions:

1. Submit one completed claim form per patient for each illness or accident.
2. All blanks must be completed. Claims can only be paid promptly if all questions are answered.
3. Attach a copy of the HCFA 1500, UB04 form or Dental Claim form. If your provider did not supply you with one of these forms, please ask your provider to complete the Service Information section below.
4. Attach all itemized bills relating to the claim. This should include a copy of the paid receipt. If applicable, pharmacy labels and UPC labels must be included.
5. Check to see that the claim form is complete and mail to the address below - ATTN: Claims.

All medical/dental/vision bills must include:

- Patient Name
- Treatment Date
- Diagnosis Codes (ICD-9)
- Itemized Charges/Paid Receipts
- Doctor's Name

All drug bills must include:

- Patient Name
- Name and Address of Pharmacy
- Date of Purchase
- Type of Medication
- Itemized Charges

Provider Information:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Federal Tax ID Number: _____ Phone Number: _____

Service Information:

***Please complete the section below if providing an invoice in lieu of a HCFA 1500, UB04 form or Dental Claim form:**

***Diagnosis Code(s):** _____

Date of Service	CPT	HCPCS	CDT	Tooth #	Surface	Unit	Amount

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