



MEMBER REIMBURSEMENT FORM

Use this form to file a claim for any eligible behavioral health expense(s) when your physician or other provider does not file claims. Please PRINT clearly or type.

1. Patient's name: (Only one patient per form)			
Last		First	Middle Initial
2. Patient's date of birth: _____		3. Patient's sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	
4. Patient's relationship to subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other (Please explain): _____			
5. Subscriber information:			
Last		First	Middle Initial
Street		City	State Zip Code
Employer:		Patient Telephone Number:	
6. Is the patient covered under any other benefit plan (including other benefits managed by TELUS Health)? <input type="checkbox"/> YES <input type="checkbox"/> NO			
If the answer is YES , please complete the following:			
Name of subscriber: _____			
Last		First	Middle Initial
Name of carrier: _____		Contract ID Number: _____	
Name and address of employer: _____			
Street		City	State Zip Code
Is the patient covered under COBRA? <input type="checkbox"/> YES <input type="checkbox"/> NO		Policy effective date: _____	
Is the patient entitled to Medicare benefits? <input type="checkbox"/> YES <input type="checkbox"/> NO		Policy effective date: _____	
7. Diagnosis(es):		8. Provider Information:	
_____ _____ _____		Last Name, Credentials First Name	
_____		Phone Number Tax ID	
_____		Street City State Zip Code	
INSTRUCTIONS: Attach the original or a copy of the itemized bill or statement from the provider. Make sure the bill contains all of the following information:			
<ul style="list-style-type: none">• Patient's Full Name• Date(s) of treatment• Description of treatment (i.e. therapy, med management)• Diagnosis (type of illness)• Charge for each treatment• Place of treatment (i.e. provider's office, hospital)			
Number of pages submitted including reimbursement form: _____			
Please sign:			
I, the undersigned, furnish the above information to permit TELUS Health to consider this claim for payment, and I certify that the included information is accurate and correct and the expenses were incurred by the above-named patient. I understand that payments will be made <u>to the subscriber</u> .			
Signature _____		Date _____	
Name (printed) _____			
MAIL OR FAX THIS FORM WITH THE ITEMIZED BILL OR STATEMENT FROM THE PROVIDER TO:			
TELUS Health PO Box 830724 Birmingham, AL 35283-0724 Fax: (205) 449-550			
REIMBURSEMENT REQUESTS CANNOT BE ACCEPTED VIA EMAIL			