Tunica-Biloxi Member Reimbursement Form

Please print clearly, complete all applicable sections and sign.
Proof of payment is required.

Submit all documents to:
Advantek Benefit Administrators
Attn: Claims Department
PO Box 45007
Fresno, CA 93718
Or Email: claims@advantekbenefit.com

Section 1: Member Information

Member ID Number:	Member Name (Last, First):	Date of Birth:	Phone:
Home Address:	City:	State:	Zip:

Section 2: Provider Information

Provider Name:	Provider Tax ID Number (optional):	Provider Phone (optional):	
Provider Address:	City:	State:	Zip:

Use a separate sheet of paper for additional services.

Date of Service	Place of Service	Procedure Code or Description	Amount Charged	Amount Paid

Section 4: Assignment of Benefits

I request that payment of authorized medical benefits is made on my behalf directly to the provider of all service(s) furnished to me.

☐ Yes ☐ No If yes, sign here - **Signature:** X____

By signing below, I am stating the information above is correct. Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete, or misleading information, may be guilty of a criminal act punishable under law and may be subject to civil penalties.

____
Tribal Member Signature

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Date