Member Reimbursement Form

Please print clearly, complete all applicable sections and sign**. Proof of payment is required.** Please submit all documents to: Advantek Benefit Administrators Attn: Claims Department PO Box 45007 Fresno, CA 93718 or email: claims@advantekbenefit.com

Subscriber ID#	Subscriber Name (Last, First, Middle)		
Patient Name (Last, First, Middle)		Date of Birth (MM/DD/YYY)	
Home Address		Relationship to Subscriber (Please circle one) Self / Spouse / Dependent / Other	
City	State	Zip	Phone

Provider Name		Provider Tax ID Number			
Provider Address					
City	State	Zip	Phone		
Date of Service	Place of Service	Diagnosis Code	Procedure Code or Description	Amount Charged	Amount Paid
Accident Related? Yes or No	If yes, Date of Accident	Accident Type (Please circle one) Work / Auto /Other (Please specify)			
How did the accident happen?					

Other Insurance Coverage

Is the patient covered by another insurance plan? Yes or No **If yes**, please provide the information below.

Name of person carrying other Insurance (Last, First)	Date of Birth	Relationship to patient:
Name of other insurance carrier	Policy Number	Employer Name

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.

Subscriber Signature _____

By signing below, I am stating that 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.

Subscriber Signature_____ **Date**_____