



**Select
Health**

Mail or Fax to:

Select Health
P.O. Box 30196
Salt Lake City, UT 84130-0196
Fax: 801-442-6580
selecthealth.org/medicare

Medical Claim Reimbursement Form

A. MEMBER INFORMATION

Name _____

Member ID# (found on your Select Health Medicare ID Card) _____

Phone# (_____) _____

Mailing Address _____

City _____ State _____ Zip _____

B. OTHER INSURANCE INFORMATION

Does the member have other insurance besides Select Health Medicare? ☐ Yes ☐ No

If yes, please complete the following:

Insurance Company _____

Is this the member's primary insurance? ☐ Yes ☐ No

Other Insurance Company Policy ID# _____

Policyholder's Name _____ Date of Birth _____
(MM/DD/YY)

Policyholder's Relationship to Member _____

C. CLAIM INFORMATION

Provider or Facility _____ Provider or Facility Tax ID _____

National Provider ID (NPI) _____ Provider Phone Number _____

Date of Service _____ Billed Amount \$ _____
(MM/DD/YY)

Description of Services _____

Procedure Code _____ Diagnosis Code ; _____

(If you do not have, or know these codes, please leave them blank.)

D. RECEIPT

Tape one receipt in this space or include it with your mail or fax submission if too large to fit here.

Medical Claim Reimbursement Instructions

To ensure that your benefits are administered correctly and without delay, complete all of the information on this form and attach a copy of your receipt. If you are submitting multiple receipts, one reimbursement form is required for each receipt. Submit claims to the address below:

Select Health

P.O. Box 30196

Salt Lake City, UT 84130-0196

Claims submitted without the proper identification numbers may be delayed or returned for additional information. If you have questions, call Member Services toll-free at **855-442-9900** during the following dates and times:

October 1 to February 14: Weekdays 7:00 a.m. to 8:00 p.m., Saturday and Sunday, 8:00 a.m. to 8:00 p.m.

February 15 to September 30: Weekdays 7:00 a.m. to 8:00 p.m., Saturday 9:00 a.m. to 2:00 p.m., closed Sunday.

Outside of these hours of operation, please leave a message. Your call will be returned within one business day. TTY users please call **711**.

Select Health is an HMO, PPO, SNP plan sponsor with a Medicare contract. Enrollment in Select Health Medicare depends on contract renewal.

Select Health obeys federal civil rights laws. We do not treat you differently because of your race, color, ethnic background or where you come from, age, disability, sex, religion, creed, language, social class, sexual orientation, gender identity or expression, and/or veteran status. This information is available for free in other languages and alternate formats.

Select Health Medicare **1-855-442-9900 (TTY: 711)** / Select Health: **1-800-538-8038**

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística.

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電。

