Medical Expense Reimbursement Form

Please follow the steps below to thoroughly and accurately complete this form.

Step 1: Complete employee information:

Employer Name: _____

Employee Name: _____

Employee Address: _____

City: _____**State:** _____ **Zip:** _____

Member ID #: _____ **Medical Effective Date**: _____

Step 2: Complete provider, hospital or clinic information:

Provider Name: _____

Address: _____

City: _____**State:** _____ **Zip:** _____

Step 3: Summary of medical expenses incurred:

Date of Service	Patient name	Relationship	Name of Provider	Phone Number	Description of Service	Copy of EOB
						Yes or No
						Yes or No
						Yes or No
						Yes or No
						Yes or No

(Please complete additional forms as needed)

Step 4: Provide copies of all EOB's and include copy of provider statement, along with any printouts related to the medical expenses incurred.

Step 5: Submit this form and all supporting documentation to:

Lifestyle Health Plans|Attn: Member Services|345 N. Riverview, Suite 600 | Wichita, Kansas 67203 |Fax- 316-616-6151

Step 6: Sign the request form:

By signing this form, I acknowledge that the statements in this request for reimbursement are true and accurate. I am claiming reimbursement for only eligible expenses incurred during the time period, which I participated in an applicable health benefit program. I certify that these expenses have not been previously submitted for reimbursement under this or any other benefit plan.

Employee Signature: _____ Date: _____

Please call us at 1-866-827-6607 to discuss any questions or other assista needed with the review and reimbursement process. Ver.010915