



Medical Expense Reimbursement Form

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

STEP 1: COMPLETE EMPLOYEE INFORMATION:

Employee Name: _____ Employer 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:

<u>DATE OF SERVICE</u>	<u>PATIENT NAME</u>	<u>RELATIONSHIP</u>	<u>NAME OF PROVIDER</u>	<u>PHONE NUMBER</u>	<u>DESCRIPTION OF SERVICE</u>	<u>COPY OF EOB</u>
_____	_____	_____	_____	_____	_____	Y or N
_____	_____	_____	_____	_____	_____	Y or N
_____	_____	_____	_____	_____	_____	Y or N
_____	_____	_____	_____	_____	_____	Y or N
_____	_____	_____	_____	_____	_____	Y or N

(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. I acknowledge that in order to be eligible for reimbursement, the expenses incurred must be submitted to Lifestyle Health Plans within 6 months of the date of service.

Employee Signature: _____ Date: _____

Questions? Please call Lifestyle Health Plans Member Services at 1-866-827-6607 if you have questions regarding your submission and the review and reimbursement process.