Medical Expense Reimbursement Form

Please follow the steps below to thoroughly and accurately complete this form.
Any missing information may delay processing.

STEP 1: COMPLETE EMPLOYEE INFORMATION			
Employee Full Name (Last name – First name – Middle name)		**Employer Name**	
Street Address	**City**	**State**	**Zip**
Home Phone	**Cell Phone**	**Email Address**	
Member ID	**Medical Effective Date**		

STEP 2: COMPLETE PROVIDER, HOSPITAL OR CLINIC INFORMATION			
Provider Name			
Street Address	**City**	**State**	**Zip**

STEP 3: SUMMARY OF MEDICAL EXPENSES INCURRED

Date of Service	Patient Name	Relationship (Spouse, Son, Daughter, Self)	Name of Provider	Provider Phone Number	Description of Service	Copy of EOB 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: 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:** _____

STEP 6: 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

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.