Claim Form

Please complete the form below and submit with provider bill to:

Inland Empire Teamsters
PO Box 5433
Spokane, WA 99205 Fax: 509.535.7883
Email: claims@rehnonline.com

EMPLOYEE INFORMATION:

Name: ______________ **Birthdate:** ______________ **Subscriber ID Number:** ______________

Address: ______________

City: ______________ **State:** ______________ **Zip:** ______________ ☐Check here if this is a new address

Employer: ______________ **Phone:** ______________

PATIENT INFORMATION (IF OTHER THAN EMPLOYEE):

Name: ______________ **Birthdate:** ______________ **Relationship:** ☐Spouse ☐Child

Mailing Address (If difference than above): ______________

City: ______________ **State:** ______________ **Zip:** ______________

PLEASE ATTACH A COMPLETE ITEMIZED STATEMENT TO THIS FORM ALONG WITH PROOF OF PAYMENT:

Please submit a legible and readable copy of an itemized statement that includes:

- Diagnosis codes (ICD10 code)
- Procedure codes (CPT code and/or HCPC code) with corresponding billed amount
- Provider name and credentialing
- Federal Tax Identification number of provider
- Provider address
- Date of service
- Member Name, Date of birth and Member number on medical card

We cannot process from a balance forward statement or receipt. Please include your payment receipt with the itemized statement. Please make sure that you are purchasing your services and/or items from valid medical providers. Companies such as Amazon, for example, will not be able to provide you an itemized statement and will not be reimbursed. If you have other insurance, please make sure to include a copy of your primary insurance Explanation of Benefits with the itemized statement.

ACCIDENTAL INJURY / THIRD PARTY LIABILITY:

Is this claim the result of an accidental injury for which another party may be responsible: ☐Yes ☐No

If NO, please provide an explanation for the injury(s) sustained.

If YES, you will need to complete and return the full accident questionnaire. This questionnaire will be mailed to.
If this is a work related injury, please file your claim with your employer's workman's compensation carrier.

Explanation of Injury:

PAYMENT INFORMATION:

Have the charges been paid in full? ☐Yes ☐No If YES, please attach proof of payment

If this plan is the secondary payer, please attach a copy of the Primary Insurance Explanation of Benefits.

FAILURE TO COMPLETE THIS FORM AND PROVIDE THE NECESSARY DOCUMENTATION COULD DELAY THE PROCESSING AND PAYMENT OF YOUR CLAIM.

______________ ______________
Signature Date