

Member Medical Claim Reimbursement Form

Member information *(print clearly)*

		Male	Female
		<input type="checkbox"/>	<input type="checkbox"/>
EPH member ID #:	DOB MM/DD/YYYY		
Last name:	First Name:	Middle initial:	
Street address:			
City:	State:	ZIP Code:	
-	-		
Phone # <i>(with area code)</i> :	Email address:		

Doctor, healthcare professional or supplier information

Provider or supplier name:			
Street address:			
City:	State:	ZIP Code:	
-	-		
Phone # <i>(with area code)</i> :	Email address:		

Claim Request *(information must match your itemized bill)*

			Reimbursement type:
/	/	\$	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision
Date of service MM/DD/YYYY	Amount paid:		<input type="checkbox"/> Hearing <input type="checkbox"/> Vaccine <input type="checkbox"/> Other

Description of procedure(s), service(s), or item(s) *(include procedure code if available)*:

Instructions:

Please read the following information below and fill out the form.

1. This form must be completely filled out in order to process your claim(s).
2. Please provide a receipt(s) for confirmation of payment.
You can mail receipt(s) to: El Paso Health Medicare Advantage
 1145 Westmoreland Dr. El Paso, TX 79925-5637
3. If you have any questions or concerns, please call Member Services at 1(833)742-3125.
(TTY 711).

Hours of operation are from:

October 1 to March 31- 8:00 am to 8:00 pm, 7 days a week

April 1 through September 30- 8:00 am to 8:00 pm, Monday through Friday

All times are in Mountain Standard Time