

# CLAIMS REIMBURSEMENT REQUEST FORM

For all non-prescription claim employee reimbursements requests including medical, dental, or vision.

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## EMPLOYER INFORMATION

Employer:

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## EMPLOYEE/MEMBER INFORMATION (As on your benefit card)

Employee's Name:

Member #:

Patient's Name:

Patient's Birth Date:

Group #:

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## IMPORTANT:

- Failure to use the correct Reimbursement Request Form may cause delay in processing your claim.
  - Be sure the patient information on the claim form is correct.
  - Original bills from the provider of the healthcare service must be provided (per plan guidelines)
  - Keep a copy of your receipt and this cover sheet for your records
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## ADDITIONAL INFORMATION

Indicate below any additional information that may be helpful in processing your request:

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**Mail this form** with paper documentation to:

**HealthSCOPE Benefits**

**Address:**

P.O. Box 16203  
Lubbock, TX 79490-6203

**Fax**

915-581-7537

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