



P.O. Box 30192 Salt Lake City, UT 84130-0192 **800-538-5038** [SelectHealth.org](http://SelectHealth.org)

## Claim Reimbursement Form

### A. SUBSCRIBER AND MEMBER INFORMATION

We only reimburse for covered services, procedures, and diagnoses. To find out if a service is covered, please call Member Services at **800-538-5038**.

Subscriber ID # (found on your Select Health ID Card) \_\_\_\_\_

Patient's Name \_\_\_\_\_ Patient's Date of Birth \_\_\_\_\_  
(MM/DD/YY)

Patient's Phone # \_\_\_\_\_

Relationship to Subscriber:  Self  Spouse  Dependent

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

### B. OTHER INSURANCE INFORMATION

Does the patient have other insurance besides Select Health?  Yes  No

If yes, please complete the following:

Insurance Company \_\_\_\_\_ Is this the patient's primary insurance?  Yes  No

Other Insurance Company Policy ID # \_\_\_\_\_

Policyholder's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
(MM/DD/YY)

Policyholder's Relationship to Patient \_\_\_\_\_

### C. CLAIM INFORMATION

Provider or Facility \_\_\_\_\_ Provider or Facility Tax ID \_\_\_\_\_  
*Required*

National Provider ID (NPI) \_\_\_\_\_ Provider Phone Number \_\_\_\_\_  
*Required*

Physical Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Mailing Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Date of Service(s) \_\_\_\_\_ Billed Amount \$ \_\_\_\_\_  
(MM/DD/YY)

Description of Services \_\_\_\_\_

Procedure Code(s) \_\_\_\_\_ Diagnosis Code (medical only) \_\_\_\_\_  
*Required* *Required*

**NOTE:** Your claim reimbursement may not be processed without a procedure and diagnosis code.

Tooth Number and Surface Letter (dental only) \_\_\_\_\_

### D. RECEIPT

**Please enclose a copy of your receipt.**

## Reimbursement Form Instructions

To ensure that your benefits are administered correctly and without delay, complete all of the information on this form. Enclose a copy of your receipt with this form. If you are submitting multiple receipts, one reimbursement form is required for each receipt. Submit claims to the address below:

**Select Health**  
**P.O. Box 30192**  
**Salt Lake City, Utah 84130-0192**

Claims submitted without the proper identification numbers may be delayed or returned for additional information. If you have questions, call Member Services at **800-538-5038** weekdays, from 7:00 a.m. to 8:00 p.m., and Saturday, from 9:00 a.m. to 2:00 p.m. TTY users, please call **711**.

Select Health obeys federal civil rights laws. We do not treat you differently because of your race, color, ethnic background or where you come from, age, disability, sex, religion, creed, language, social class, sexual orientation, gender identity or expression, and/or veteran status.

This information is available for free in other languages and alternate formats.

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística.

**注意:如果您使用繁體中文, 您可以免費獲得語言援助服務。請致電**

Select Health Medicare: **855-442-9900** (TTY: **711**) / Select Health: **800-538-5038**