MEDICAL Reimbursement Claim Form

COMPLETE the following and attach your receipt of payment. *Incomplete forms will not be processed.*

To be completed by Employee:

1. Employee's Member ID Number:_____
2. Employee's name: Last_____ First: _____
3. Employee's mailing address: _____

   City_____ State_____ Zip_____
4. Phone number: _____
5. Patient's name: Last_____ First: _____
6. Patient's Date of Birth: _____
7. Does the patient have other medical coverage: Yes_____ No_____

   Name of other insurance company:_____

   Policy number:_____ Effective date:_____
8. Is treatment related to an injury: Yes_____ No_____

   If yes, How_____

   When_____

   Where_____

Employee Signature: _____Date: _____

To be completed by Provider (unless purchased equipment through a retailer)

1. Provider name/facility:_____
2. Address: _____
3. NPI: _____ Tax ID: _____
4. Phone number: _____

Services Rendered:

1. Date of Service: _____
2. Dx Codes: _____, _____, _____,__ _____, _____
3. CPT Codes: _____, _____,_____, _____, _____

Completed by: _____Date: _____

Amount paid: _____ Form of Payment:_____

Mail completed form to:
Samera Health
PO Box 126
Smithfield UT 84335

For Samera Health use Only: Claim#_____

Fax claims to: 435-563-4035
Email: claims@samerahealth.com