Member Claim Reimbursement Form

MEDICAL, DENTAL, VISION, MASSAGE, AND CHIROPRACTIC SERVICES

EMPLOYER INFORMATION

Employer Name:

PATIENT'S INFORMATION (who received the service and who you are claiming the benefit/reimbursement on)

Patient: ☐ **Employee** ☐ **Spouse** ☐ **Dependent**

Name:

Member #: Group #:

REIMBURSEMENT INFORMATION

What is the Service you are requesting reimbursement for?

What was the date of service?

Provider Name: Provider Tax ID:

Provider Address:

Provider NPI:

Total Amount Paid related as Shown on Receipt:
(***Do not include amounts paid for taxes, warranties, or shipping and handling***. Please include the itemized receipt with your submission.)

Do you want WebTPA to reimburse: You (member) ☐ **Provider** ☐

By submitting this reimbursement form, I acknowledge that what is listed above is true and accurate. Any individual who willfully and knowingly engages in activities intende to deraud the health plan my face consequences up to and including prosecution to the fullest extent of the law.

Keep a copy of this form and any supporting documentation for your records.

NOTES/COMMENTS

SUBMIT

Online Submission
WebTPA Member Portal: **webtpa.com**

Mail:
P.O. Box 99906
Grapevine, TX 76099-9706

Fax:
(469) 417-1960

QUESTIONS

Please call member services at **888-276-4732**

Reimbursement for claims will be processed according to the benefits outlined in the ***Summary Plan*** document, which can be found at **ascendtowholeness.org**.