ascend
TO WHOLENESS HEALTHCARE PLANS

Claims Reimbursement Form

MEDICAL,DENTAL, VISION, MASSAGE, AND CHIROPRACTIC SERVICES

EMPLOYER INFORMATION

Employer Name:

MEMBER INFORMATION (as on your healthcare card)

Covered Employee *(not dependent)*

Name: Member #:

Group #:

PATIENT'S INFORMATION

Patient is ◉ Self ○ Dependent

Dependent's Name:

REQUIRED DOCUMENTATION

Please attach/include the following on your claim reimbursement submission to ensure prompt processing.
You can obtain all the required documentation from your provider's office.

1. Provider name, address, Tax ID and NPI number
2. Original itemized, legible invoice/receipt with procedure and diagnosis code(s) for care received
3. Date of service

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

Do you want WebTPA to reimburse ◉ You (member) ○ Provider

Notes/Comments:

SUBMIT

Online Submission:
WebTPA Member Portal:
webtpa.com

Mail:
WebTPA
An AmWINS Group Company
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**.