IF YOU SELF-PAY, HERE'S HOW TO FILE

PAID OUT OF POCKET

Lucent Health Plan Claim Reimbursement Form — four steps to get paid back.

1 BEFORE YOU LEAVE

Ask for the Superbill

Tell the provider you intend to file for insurance benefits. The Superbill must show patient name, date of service, diagnosis codes, procedure codes, amount paid, and the provider's tax ID, name and billing address.

2 FILL IT OUT

Complete every section

Print clearly and complete the form in its entirety. Mark anything that doesn't apply as "N/A." Sign and date at the bottom — a claim for a spouse or adult dependent child needs their signature too. Unsigned or incomplete forms get returned.

3 ATTACH

Include proof of payment

Any amount the plan pays goes to the provider unless you attach your receipt. Attach it and check the box so the reimbursement comes to you.

4 SEND IT IN

Mail, fax or email

Mail: P.O. Box 211466, Eagan, MN 55121

Fax: 615-255-6654, Attn: Member Reimbursement Team

Email: MedicalMemberReimbursement@lucenthealth.com

That inbox is no-reply — call the number on your ID card for claim status.

FILE WITHIN 364 DAYS OF THE DATE OF SERVICE

Claims received later are not eligible for payment. Submitting the form does not guarantee reimbursement.

Having preventative medical services? Contact PERMA FAIR and request a Virtual Credit Card for the payment.

Reimbursement is for the plan's responsibility — you are always responsible for your patient responsibility.

PERMA FAIR HEALTH AND PHARMACY · Michaels · Lucent Health

Questions? Call the number on your Benefits ID Card.

EXAMPLE OF COMPLETED LUCENT CLAIM REIMBURSEMENT FORM

SAMPLE DATA ONLY

P.O. Box 211466, Eagan, MN 55121 · Fax 615-255-6654 · MedicalMemberReimbursement@lucenthealth.com

IMPORTANT — READ CAREFULLY

1. Complete this form in its entirety.

2. Indicate "Not Applicable" or "N/A" if a section does not apply.

3. Be sure to sign and date this form at the bottom.

4. Include the provider's "Superbill" showing patient name, date of service, diagnosis and procedure codes, amount paid, and provider tax ID, name and billing address.

5. Amounts paid by the Plan go to the provider unless you attach proof of payment.

6. Mail to P.O. Box 211466, Eagan, MN 55121; fax 615-255-6654 (Attn: Member Reimbursement Team); or email MedicalMemberReimbursement@lucenthealth.com.

SECTION I: INSURED / SUBSCRIBER INFORMATION

Full Name (as it appears on your paycheck)	Group Number	Member ID
Jane Doe	**MO-40817**	**LH88472913**

Date of Birth	Number & Street
04/12/1986	**118 Larchmont Ave**

City	State	Zip Code
Cherry Hill	**NJ**	**08002**

Email Address	Telephone Number
jane.doe@email.com	**856-555-0142**

Employer
The Michaels Organization

SECTION II: CLAIMANT (PATIENT) INFORMATION

Patient's Name	Relationship
Jane Doe	**☒ Self ☐ Spouse ☐ Child**

Gender	Date of Birth
☐ Male ☒ Female	**04/12/1986**

SECTION III: PROVIDER INFORMATION

Provider Name and Address	Tax ID (TIN)
Riverbend Family Practice, Cherry Hill, NJ	**22-3456789**

SECTION IV: ACCIDENT, INJURY, OR WORK RELATED ILLNESS

Due to accident, injury or work related illness?	Date Occurred
☐ Yes ☒ No — skip to Section V	**N/A**

SECTION V: AUTHORIZATION & SIGNATURE

I/We certify the above information is true and correct, and authorize providers rendering care to furnish Lucent Health with full information regarding treatment. A claim for a spouse or adult dependent child must also carry their signature.

Employee Signature	Spouse / Adult Dependent	Date
Jane Doe	**N/A**	**08/14/2026**

ATTACHED SUPERBILL

DOS 07/29/2026 · Dx Z00.00, E78.5 · CPT 99396, 36415 · Paid $318.00 · Riverbend Family Practice, TIN 22-3456789, PO Box 4412, Cherry Hill, NJ 08034

☒ Receipt attached
Fax 615-255-6654
Attn: Member Reimbursement Team

EXAMPLE OF A PROVIDER SUPERBILL

A Superbill is the provider's itemized record of your visit — diagnosis and procedure codes, charges, and what you paid. Ask for it before you leave the office and attach it to your completed claim form.

SAMPLE DATA ONLY

Riverbend Family Practice

SUPERBILL

210 Oak Street, Cherry Hill, NJ 08002 · 856-555-0400
Billing: PO Box 4412, Cherry Hill, NJ 08034 · Tax ID (TIN) 22-3456789 · NPI 1487562930

Patient Name	Date of Birth	Date of Service	Statement Date
Jane Doe	04/12/1986	07/29/2026	07/29/2026

DATE	CPT / HCPCS	DESCRIPTION OF SERVICE	DX	CHARGE
07/29/2026	99396	Preventive medicine visit, established patient, 40–64 years	Z00.00	$268.00
07/29/2026	36415	Collection of venous blood by venipuncture	E78.5	$50.00

Diagnosis codes: Z00.00 — routine general medical examination · E78.5 — hyperlipidemia, unspecified	Total Charges	Amount Paid by Patient	Balance
	$318.00	$318.00	$0.00

SIX THINGS THE SUPERBILL MUST SHOW

- ☒ Patient name
- ☒ Date of service
- ☒ Diagnosis codes
- ☒ Procedure codes
- ☒ Amount paid
- ☒ Provider tax ID, name and billing address

Paid in full at time of service. Receipt issued and attached as proof of payment.

Provider signature

A. Whitfield, MD

PERMA FAIR HEALTH AND PHARMACY · Michaels · Lucent Health

Sample data shown for illustration only.