IMPORTANT - READ CAREFULLY

1. Please complete this form in itsentirety.
2. Indicate"NotApplicable"or"N/A"ifasectiondoesnotapply.
3. Be sure to sign and date this form at the bottom.
4. Be sure to include the provider's "**Superbill**". **Let your provider know that you intend to file for insurance benefits and need the Superbill for the claim.** The Superbill must include: patient name, date of service, diagnosis codes, procedure codes, amount paid, and provider information including tax ID, name and billing address.
5. Any amounts paid by the Plan will be paid to the provider unless you attach proof of payment. Check here if receipt attached. ☐
6. Submit this completed form and Superbill via fax or email:
   - Fax: 615-255-6654 Attn: Member Reimbursement Team
   - Email: MedicalMemberReimbursement@lucenthealth.com
   - Note: This is a no-reply email. Please call the number on your ID card for claim status.

Note: This form may be returned if not properly completed and signed.

Lucent Health

P.O. Box 211466 Eagan, MN. 55121 Fax: 615-255-6654

HEALTH PLAN CLAIM REIMBURSEMENT FORM–please print clearly

Section I: Insured/Subscriber Information

Full Name (as is appears on your paycheck)	Group Number (from ID Card)	Member ID (from ID card)	Date of Birth

Home Address	*Number & Street*	*City*	*State*	*Zip Code*

Email address	Telephone Number

Employer

Section II: Claimant (patient) Information

Patient's Name	Patient's Relationship to Subscriber	Gender	Date of Birth
	Self ☐ Spouse/Domestic Partner ☐ Child ☐	Male ☐ Female ☐	

Section III: Provider Information

Provider Name and Address	Tax ID Number (TIN)

Section IV: Accident, Injury, or Work Related Illness Information

Is your medical claim due to an accident, injury or work related illness?	Date Accident/Injury Occurred:	Did accident/injury happen at work?
Yes ☐ No ☐ If "no", skip to section V.		Yes ☐ No ☐ Was illness work-related? Yes ☐ No ☐

Describe accident or injury (tell how, when, and where it occurred).

Section V: Authorization & Signature

I/We jointly certify that the above information is true and correct. I/We hereby authorize all doctors, pharmacists, hospitals or other institutions rendering care and treatment to furnish Lucent Health with full information regarding treatment rendered (including copies of their records). I/We also authorize any Union, Trust Fund, Employer or Insurance Carrier to furnish Lucent Health with information regarding benefits to which I/We may be entitled. (If claim for spouse or adult dependent child, they also must sign). A copy or photocopy of this authorization shall be considered as effective and valid as the original.

Employee Signature	Spouse/Adult Dependent Child Signature	Date

Claims must be received by Lucent Health within 364 days of the date of service; claims not received within this time frame are not eligible for benefit payment. Submission of this form does not guarantee reimbursement. For any questions, please contact the customer support number on your ID card.