

School District of Upper Dublin

Personal Choice Outpatient Deductible Reimbursement Claim Form

Employee Name: _____ Social Security Number _____
 (Last First Middle)
 Address: _____ City _____ State _____ Zip _____
 Street

A. Explanation of Benefits Information: NOTE: YOU MUST SUBMIT YOUR PERSONAL CHOICE EXPLANATION OF BENEFITS SHOWING UNREIMBURSED OUTPATIENT DEDUCTIBLE AMOUNTS.

Name of Patient: (Last First Middle)	Relation- ship to employee:	Amount of Outpatient Deductible Not Paid:	Date(s) of Service:	Nature of Outpatient Service
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

B. OFFICE USE ONLY:

PROCESSED: [] OPERATOR: []
 REIMBURSEMENT DATE: []
 CHECK INFORMATION: []

C. Claims Procedure:

1. Please complete this form, sign and date at the bottom. Use this form to obtain reimbursement for any excess Outpatient Deductibles you have paid as the result of your Personal Choice Healthcare Plan.
2. You must submit your Personal Choice Explanation of Benefits (EOB) to obtain reimbursement. This Explanation of Benefits must include your name, address and your Plan ID Number. Claims not including EOB's will be returned. EOB's must show deductible amounts not paid by Personal Choice.
3. You will be reimbursed on the 1st & 15th of each Plan month.

D. Signature:

I certify that the claims for which I am seeking reimbursement are the result of a Personal Choice 215 Plan Outpatient Deductible and that the information I have provided regarding these services is accurate. Submit to: Claims Department, DeHEY McANDREW - PO Box 447 - Scranton, PA. 18501.

 (Signature of Employee) _____ / _____ / _____
 (Date)