United Employees Benefit Trust
Non-Profit Provider of Employee Benefits Since 1965

Address: 220 S 27th St #B * Tacoma WA 98402
Phone: (253) 474-1214
Fax: (253) 474-7180
E-mail: claims@unitedemployees.org
Website: www.unitedemployees.org

Request for Reimbursement Claim Form

Please use this form to submit reimbursement requests when you have medical expenses from a provider who does not bill Premera directly.

1. Complete the information below.
2. Attach itemized bills which must include the patient's name, date of service, charges, diagnosis and procedures codes.
3. Retain copies for your records as receipts will not be returned.
4. Sign the completed form and submit claim to UEBT at the address, fax or email listed above.

Do not use this form when requesting reimbursement for dental, vision or prescription services. These requests will need to be sent to: VSP for vision; Delta Dental of WA for dental and VytlOne for prescription. Links to these carriers can be found on the UEBT website.

MEMBER and PATIENT INFORMATION (See ID Card)

Subscriber Name (Name on ID Card) _____

Prefix _____ ID number _____ Group number _____

Patient Name (First, MI, Last) _____

Mailing Address _____

Patient's Relationship to Subscriber _____ Patient's Birthday _____

Phone number to call if there are any questions regarding this reimbursement request _____

PHYSICIAN or SUPPLIER INFORMATION

Itemized billing/receipt must contain: The provider's name, address, tax ID number (TIN) and national provider identifier number (NPI); the date of service, procedure code(s), diagnosis code(s), place of service code, itemized charges and amount paid by the patient.

Provider's name (if not on itemized receipt): _____

Is this claim the result of an accident or injury? ☐ Yes ☐ No If yes, how, where and date injury occurred _____

_____

_____

OTHER INSURANCE INFORMATION

Are you or any family members covered by Medicare? ☐Yes ☐No If YES, please specify ☐Part A ☐Part B ☐Part C

Are you or any family members covered under other health insurance? ☐ Yes ☐ No

If YES, specify the type of coverage below and if coverage is an: ☐ Employer Plan ☐ Individual Plan ☐ COBRA

Medical ☐ Yes ☐ No Prescription ☐ Yes ☐No Dental ☐ Yes ☐ No Vision ☐ Yes ☐ No

If the answer is YES to either of the above questions, please include a photocopy of the front and back of the insurance ID card.

SIGNATURE

To be accepted, this form must be completed in full, signed and have an itemized billing attached.

_____ _____ _____

Patient Signature (or legal guardian) Printed Name Date