Out-of-Network Specialist Visit Reimbursement Form

Member Information

Full Name

Member ID

Date of Birth

Phone Number

Mailing Address

Specialist Information

Provider Name

Provider Address

Provider Phone

Provider NPI (if known)

Visit & Reimbursement Details

Date of Visit

Amount Paid

Reason for Specialist Visit

Attach Itemized Receipt/Superbill

Choose File No file selected

Additional Information (optional)