

Request For Reimbursement Of Certain Medical Expenses

You are required to complete this form, and submit it to P.R.I.M.E. Benefit Systems, if your employer's health plan design includes reimbursement for a portion of certain tests, and/or an Emergency Room visit. This will allow P.R.I.M.E. to match this form with your applicable Wellmark Blue Cross Explanation of Benefits (EOB) statement. Once P.R.I.M.E. receives this form and your EOB, a reimbursement check will be mailed directly to your home.

Please Complete The Following:

Employee's First Name: _____ and Last Name _____

Employee's Soc Sec Number *or* "BDID" number (see Note A): _____

Note A: Employee's BDID identifier is the Employee's date of birth (MMDDYYYY) and the last 4 digits of their social security number. The BDID can be used instead of your social security number to avoid identity theft.

EXAMPLE: Employee's date of birth is 03/09/1973 and their social security number is 485-09-0874. Their BDID would be 030919730874.

If the PATIENT was different than the Employee:

Patient's First Name _____ and Patient's Last Name _____

Check the TYPE of service:

- Mammogram
- Colonoscopy
- Sigmoidoscopy

Enter Date the Service was performed: _____

Employee's Signature: _____ Date Signed: _____

INSTRUCTIONS: You may mail, FAX, or e-mail a scanned image of this form to P.R.I.M.E.:

By mail: P.R.I.M.E. Benefit Systems, Inc.
P.O. Box 2239
Cedar Rapids, IA 52406-2239

By FAX: (319) 395-7498

By e-mail: CustomerService@primebenefitsystems.com

Questions? Please call P.R.I.M.E. at 319-294-4045