



CLAIM REIMBURSEMENT REQUEST FORM

ADVENTIST RISK MANAGEMENT, INC.

Providing Solutions to Minimize Risks

This form to be used for the following services only

This claim is for: (Please Select **One**)

Acupuncture Vision LASIK
 Chiropractic Hearing Aid
 Massage Adult Immunization

Employer Information

Employer: _____

Group No: _____

(As noted below Employer Name on face of ARM/Medco Benefit Card)

Employee / Member Information

Employee's Name: _____ Member ID: _____

Patient's Name: _____ Patient's Birth Date: _____

Reimbursement Information

Pay Employee: _____

Pay Provider: _____

IMPORTANT

- Failure to use the correct Reimbursement Request Form may cause delay in processing your claim.
- Be sure the patient information on the claim form is correct.
- Original bills from the provider of the healthcare service must be provided.
- Keep a copy of your receipt and this cover sheet for your records.

Mail This Form with Proper Documentation and Receipts to

Adventist Risk Management, Inc, PO Box 1021, Horsham, PA 19044-1021