Experience Health Member-Submitted Claim Form

You <u>can</u> use this form for:	You <u>cannot</u> use this form for:
✓ **Medical Claims** ✓ **Supplemental Dental Claims** ✓ **Vision Claims**	✗ **Part D (Drug) Claims** **(click here for the Part D form)**

Use this form to request reimbursement for covered medical, vision or dental services that you paid for and were not billed to Experience Health by your provider.

To determine if a service is covered, please call Customer Service (1-833-777-7394). The yearly maximum allowance for supplemental dental or vision services can be found in your Evidence of Coverage (EOC).

To be reimbursed for covered services that you paid for in full, you must:

- Complete this form
- Attach itemized bill from provider
- Attach paid receipts

Member's Name:		
Member's ID Number:	Date of Birth:	
Member's Address:		
City:	State:	Zip:
Signature:		Date:

Before mailing, check these things:	Send the completed claim form and all required documentation to:
✓ Print or type using blue or black ink ✓ Include all documentation ✓ Make a copy of the documentation that you send to us for your records ✓ Submit claims within 12 months of the date of service	Experience Health Attention: Claims Dept. PO Box 3633 Durham, NC 27702