Insurance Benefit Administrators℠

Insurance Benefit Administrators
PO Box 2943
Shawnee Mission, KS 66201-1343
Phone: 844-630-7500
FAX: 913-901-0534

To submit for a claim reimbursement, please submit this form and all documentation to:

Insurance Benefit Administrators
PO Box 2943
Shawnee Mission, KS 66201-1343

Or electronically to: **clientservices@insurancebenefitadministrators.com**

Member's Information

Policy ID (as shown on ID Card) _____

Member's Full Name _____

Member's DOB (MM/DD/YYYY) _____

Date of Service (MM/DD/YYYY) _____

For Medical claims use – Please submit the above Member's information along with the following documentation:

☐ An itemized bill from the provider/facility – The bill must contain:

- ☐ Patient's name
- ☐ Provider's Name and Tax ID#
- ☐ Diagnosis, and CPT codes for services provided
- ☐ the date of Service
- ☐ Charge amount for each service provided

For Rx claims use – Please submit the above Member's information along with the following documentation:

A receipt or any documentation showing:

- ☐ Date of fill
- ☐ Drug name
- ☐ NDC number

Optional – The prescribed Rx drug(s) is a Generic (YES/NO). Leave blank if unknown. _____

Questions? Please call Insurance Benefit Administrators at 844-630-7500 or email clientservices@insurancebenefitadministrators.com for assistance.