El Paso Health Advantage Dual SNP

Member Medical Claim Reimbursement Form

Member information (*print clearly)*

	/ /	**Male** ☐	**Female** ☐
EPH member ID #:	**DOB MM/DD/YYYY**		
Last name:	**First Name:**		**Middle initial:**
Street address:			
City:		**State:**	**ZIP Code:**
Phone # *(with area code)*: - -	**Email address:**		

Doctor, healthcare professional or supplier information

Provider or supplier name:		
Street address:		
City:	**State:**	**ZIP Code:**
Phone # *(with area code)*: - -	**Email address:**	

Claim Request *(information must match your itemized bill)*

/ /	**$**	**Reimbursement type:** ☐ Medical ☐ Dental ☐ Vision ☐ Hearing ☐ Vaccine ☐ Other
Date of service *MM/DD/YYYY*	**Amount paid:**	

Description of procedure(s), service(s), or item(s) *(include procedure code if available)*:

Instructions:

Please read the following information below and fill out the form.

1. This form must be completely filled out in order to process your claim(s).

2. Please provide a receipt(s) for confirmation of payment.
   You can mail receipt(s) to: El Paso Health
   1145 Westmoreland Dr.
   El Paso, TX 79925-5637

3. If you have any questions or concerns, please call Member Services at 1(833)742-3125. (TTY 1-855-532-3740).

   Hours of operation are from:
   October 1 to March 31- 8:00 am to 8:00 pm, 7 days a week
   April 1 through September 30- 8:00 am to 8:00 pm, Monday through Friday

   All times are in Mountain Standard Time