SHARP CLAIM REIMBURSEMENT REQUEST FORM

This form to be used for the following services

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

[ ] Dental [ ] Vision [ ] Hearing Aid [ ] Chiro [ ] Other

Group Information

Group Name: **SHARP (Supplemental Healthcare Adventist Retirement Plan)** Group No: **100110**

Retiree / Member Information

Retiree's Name: _____
Patient's Name: _____
Patient's Birth Date: _____
Member #: _____

(As noted below Retiree's Name on face of ARM/Supplement Benefit Card)

Reimbursement Information: (Please Select One)

[ ] Pay Retiree: [ ] 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 1928
GRAPEVINE TX 76099-1928
OR FAX# 469-417-1760