MESSA
Good health. Good business. Great schools.

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Claims Reimbursement Form

Please complete this entire form and attach/include as much information as possible.

MESSA Member / Patient Information *(Please Print)*

First Name of **Member**	Last Name of **Member**		Enrollee ID Number
First Name of **Patient**	Last Name of **Patient**		Patient's Date of Birth (MM/DD/YY)
Address			Home Phone # ( )
Address 2			School District
City	State	Zip Code	Work / School Phone # ( )

Claim Information

Type of Service:	Procedure Code:
Individual Charge Detail for Each Type of Service:	
Diagnosis:	Diagnosis Code Number:

Important Note: *Your bill/receipt must accompany this form for processing.*
Please remember to attach your itemized bill/receipt for reimbursement consideration.

Provider Information

Name of Provider or Facility			Degree
Address			Tax ID Number
Address 2			National Provider Identification (NPI) Number
City	State	Zip Code	Telephone Number ( )

Reimbursement Instructions

Send payment to: ☐ Member ☐ Provider