ACS Benefit Services, Inc.
Third Party Administrator
P. O. Box 2000
Winston-Salem, NC 27102-2000

Phone: (336) 759-2013
Fax: (336) 759-1066
Toll Free: 800-849-5370

MEDICAL CLAIM REIMBURSEMENT FORM

Action Required by Subscriber:

1. **Enter all requested information in the space provided on this form. Failure to provide all requested information will delay the processing of your claim.**
2. **Attach the following documentation:**
   a. **Medical Claims –the original EOB issued by your medical plan, if applicable, or the patient's copy of the provider's bill showing date of treatment, type of service and amount of charges**
   b. **Prescription Claims – receipts showing name and address of pharmacy, name of patient, date of purchase, prescription number, name of medication and charge**
3. **Sign and Date this form.**
4. **Mail the completed form and the supporting documentation to:**

ACS Benefit Services, Inc.
P. O. Box 2000
Winston-Salem, NC 27102-2000

Subscriber Name		Subscriber Address	
Subscriber ID Number	Daytime Phone #	Plan Name	Plan SF #
Claimant Name		Claimant Date of Birth: ______/______/______ Month Day Year	
Type of Claim (Check One)	Medical [ ]	Prescription [ ]	

I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT

I ALSO UNDERSTAND THAT THE PRIVACY STANDARDS OF THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT REGULATIONS AUTHORIZE A COVERED ENTITY/HEALTH CARE PROVIDER TO RELEASE PROTECTED HEALTH INFORMATION TO ACS BENEFIT SERVICES, INC. FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS PURPOSES.

Subscriber Signature: ____ **Date:** ______________________