



Member Reimbursement Claim Form

Please do not use this form for International Claims

Instructions for Submitting Claims

1. Submit a claim only when you are billed for services from a provider that does not directly submit a claim to WEA Trust.
2. Submit a separate form for each patient.
3. Attach an **original** itemized bill from your provider (required information is on the second page of this form).
4. Keep a copy of all bills and claim forms submitted (originals will not be returned).
5. Be sure to sign and date the completed form.
6. **Claims must be submitted within 90 days of the date of service.**
7. **Mail this claim form and all attachments to:** WEA Trust
 PO Box 211438
 Eagan, MN 55121-3038

Requested Reimbursement Amount

\$

Please complete using black ink only

Subscriber (plan holder) Information

Subscriber Identification # _____	Last Name _____	First Name _____	Middle Initial _____
Address (number and street) _____	City _____	State _____	Zip Code _____
Date of Birth (MM/DD/YY) _____	Group Number/Group Name _____		

Patient Information

Patient Last Name _____	First Name _____	Middle Initial _____	Date of Birth (MM/DD/YY) _____
Gender: <input type="checkbox"/> Male	Patient is: <input type="checkbox"/> Subscriber (plan holder)		
<input type="checkbox"/> Female	<input type="checkbox"/> Child/Dependent		
	<input type="checkbox"/> Spouse (of plan holder)		
	<input type="checkbox"/> Other (specify) _____		

Other Coverage

Does the patient have other insurance?
 No
 Yes

If Yes: _____ (write effective date below)
 Medicare Part A (Hospital) _____
 Medicare Part B (Medical) _____
 Medicare Part D (Pharmacy) _____
 Other Insurance Plan _____

Identification number on other insurance plan _____

 Auto insurance policy number _____
 Name and address of other insurance _____

Was the treatment for ...

An accident at work?
 No
 Yes, date of accident _____

Auto accident?
 No
 Yes, date of accident _____
 Yes, name of auto insurance _____

Other accident?
 No
 Yes, date of accident _____

I authorize the release of any medical or other information necessary to process this claim.

Signature _____

Date _____

Please allow up to 30 days for your claim to process

Filing Claims

- **You will need to submit an itemized bill that must contain the following required information.**
 1. A billing statement from the provider that **MUST** include all of the following:
 - Provider name
 - Provider address
 - Provider Tax Identification Number/National Provider Identification Number
 - Provider credentials, i.e., the initials associated with the educational degrees the provider has earned, such as MD
 2. Patient's name
 3. Date(s) of service
 4. Itemized charges for each date of service and type of service received
 5. Procedure codes (CPT/HCPCS/Revenue codes) for all services received
 6. Diagnosis code(s) for services received
 7. Number of units (this is the number of times a service was performed on a particular date of service)
- **Attach any related claim summaries or Explanation of Benefits Forms you may have received for these services, including those received from Medicare or other insurance companies.**
- **When submitting a **reimbursement request for diabetic supplies**, you must submit an itemized receipt from your pharmacy that includes:**
 - National Drug Code
 - Name of Drug
 - Date dispensed
 - Quantity dispensed
 - Name of prescribing physician
- **Please provide proof of payment (a copy of the canceled check or a receipt that indicates payment was made by the member).**

PLEASE NOTE: Any prescriptions submitted to WEA Trust in error will be returned to you.

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90 days of the date of service.**