IMPORTANT - READ CAREFULLY

1. Please complete this form in its entirety.
2. Indicate "Not Applicable" or "N/A" if a section does not apply.
3. Be sure to sign and date this form at the bottom.
4. Be sure to include the provider's "**Superbill**". **Let your provider know that you intend to file for insurance benefits and need the Superbill for the claim.** The Superbill must include: patient name, date of service, diagnosis codes, procedure codes, amount paid, and provider information including tax ID, name and billing address.
5. If the Superbill does not reflect a paid amount, please also submit a receipt for payment.
6. Submit this completed form and Superbill via fax or email:
   - Fax: 615-255-6654 Attn: Mailroom
   - Email: mblackman@naa-lp.com

Note: This form may be returned if not properly completed and signed.

Lucent Health

P.O. Box 1984 Nashville, TN 37202
Fax: 615-255-6654

HEALTH PLAN CLAIM REIMBURSEMENT FORM–please print clearly

Section I: Insured/Subscriber Information

Full Name (as is appears on your paycheck)	Group Number (from ID Card)	Member ID (from ID card)	Date of Birth

Home Address *Number & Street* *City* *State* *Zip Code*

Email address	Telephone Number

Employer

Section II: Claimant (patient) Information

Patient's Name	Patient's Relationship to Subscriber	Gender	Date of Birth
	Self ☐ Spouse/Domestic Partner ☐ Child ☐	Male ☐ Female ☐	

Section III: Provider Information

Provider Name and Address	Tax ID Number (TIN)

Section IV: Accident, Injury, or Work Related Illness Information

Is your medical claim due to an accident, injury or work related illness?	Date Accident/Injury Occurred:	Did accident/injury happen at work?
Yes ☐ No ☐ If "no", skip to section V.		Yes ☐ No ☐ Was illness work-related? Yes ☐ No ☐

Describe accident or injury (tell how, when, and where it occurred).

Section V: Authorization & Signature

I/We jointly certify that the above information is true and correct. I/We hereby authorize all doctors, pharmacists, hospitals or other institutions rendering care and treatment to furnish Lucent Health with full information regarding treatment rendered (including copies of their records). I/We also authorize any Union, Trust Fund, Employer or Insurance Carrier to furnish Lucent Health with information regarding benefits to which I/We may be entitled. (If claim for spouse or adult dependent child, they also must sign). A copy or photocopy of this authorization shall be considered as effective and valid as the original.

Employee Signature	Spouse/Adult Dependent Child Signature	Date

Claims must be received by Lucent Health within 364 days of the date of service; claims not received within this time frame are not eligible for benefit payment. Submission of this form does not guarantee reimbursement. For any questions, please contact us at 888-201-4066.