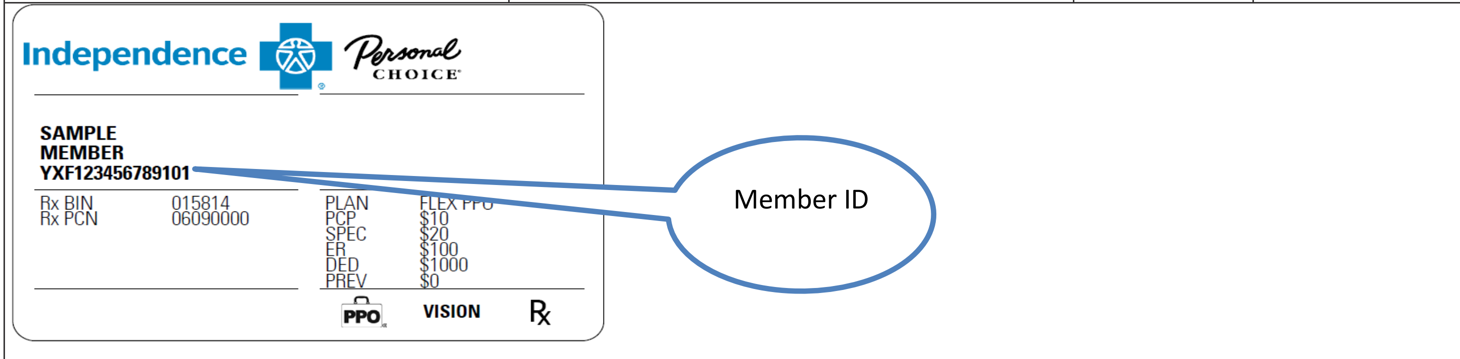
School District of Philadelphia

EPI PEN REIMBURSMENT CLAIM FORM

MEMBER INFORMATION:		
MEMBER'S NAME (First, Middle, Last)	CONTACT PHONE #	MEMBER ID NUMBER

PATIENT INFORMATION:			
PATIENT'S NAME (First, Middle, Last)	RELATIONSHIP OF PATIENT TO MEMBER ___ SELF ____SPOUSE ____ CHILD ____ OTHER	SEX ___ MALE ___ FEMALE	BIRTH DATE / /



FAX THIS FORM AND DOCUMENTATION TO:

COLLEEN MCSWEENEY

Fax 215-640-7450

Email: Colleen.McSweeney@ibx.com

Register receipt and the Rx label must be sent with this form.

I certify that the information provided on this claim form is correct and complete, and that I am claiming benefits only for charges actually incurred by the patient named. I authorize any hospital, physician or other provider who participated in the care and treatment of the patient to release to Independence Blue Cross all medical or other information requested for the processing of this claim. I hereby agree to reimburse Independence Blue Cross in full should this claim be incorrectly paid. Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material there to commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

______________________	____________	________________	________________
MEMBER'S SIGNATURE	DATE	(AREA CODE) HOME PHONE	(AREA CODE) WORK PHONE

INSTRUCTIONS:

Remember: This claim form should only be used when requesting reimbursement for epi-pens.

1. Please complete the Member/Patient Section of the Form, including
   - Members Name, contact phone #, and member id

2. Attach all itemized bills to this form. Bills should include the following information:
   - Include the Register receipt and the Rx label
   - PATIENT'S full name
   - DATE AND AMOUNT CHARGED

3. When you have already paid the provider in full for the epi-pen, payment should be made to you (if you are our member). Please be sure to mark "PAID IN FULL" clearly on the bill.

4. If submitting expenses for more than one family member, please use a SEPARATE claim form for each person.

5. Complete the entire claim form and be sure to include the information requested above. This will avoid unnecessary delays in processing your claim. Keep a copy of this form and itemized bills for your records

6. If you have QUESTIONS regarding the completion of this claim form, please contact the SDP Account Contact, Colleen McSweeney at Colleen.McSweeney@ibx.com or Fax 215-640-7450