

Member Reimbursement Form

This form is used when payment was made directly to your provider.
Please fill out, sign, and mail this form with original receipts to:

WMAHP Member Correspondence
P.O. Box 211501
Eagan, MN 55121

Member ID: <i>(found on your Wellmark Advantage Health Plan ID card)</i>			
First Name:		Last Name:	
Street Address:			
City:		State:	ZIP code:
Date of Birth:	Phone Number:	Date of Service:	Was this Related to an Auto Accident? Yes ☐ No ☐
Was this Work Related? Yes ☐ No ☐		Other Health Insurance? Yes ☐ No ☐	
Name of other Health Insurance:		Policy Number:	
In order to process your request, please: - Complete one form for each service - Mail original itemized bill that includes the following: - Provider name and NPI - Date of service - Charge - Procedure description and/or code* - Diagnosis description and/or code* <i>*Doesn't apply for flu shots</i> - Please keep a copy of your original bill for your files			
I certify the above information is true, and the enclosed material is correct and unaltered.			
Signature:			Date: