



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/VISION CARE 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 billed
 - b. Prescription Claims – receipts showing name and address of pharmacy, name of patient, date of purchase, prescription number, name of medication and charge
 - c. Vision Claims – the original itemized receipt for the services rendered
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

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|--|------------------------|---|------------------|
| <u>Subscriber Name</u> | | <u>Subscriber Address</u> | |
| <u>Subscriber ID Number</u> | <u>Daytime Phone #</u> | <u>Plan Name</u> | <u>Plan SF #</u> |
| <u>Claimant Name</u> | | <u>Claimant Date of Birth:</u> ____/____/____ Month Day Year | |
| <u>Type of Claim (Check One)</u> Medical [<input type="checkbox"/>] Vision [<input type="checkbox"/>] Prescription [<input type="checkbox"/>] | | | |
| 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: _____ | |