SOVEREIGN NATIONS INSURANCE

Medical Claim Reimbursement Form

COMPLETE THE FORM IN FULL. The form must be signed by the member or patient.

Also attach an itemized document from the provider detailing the provider's billing information and NPI #, CPT service codes and ICD-10 codes billed.

Examples of acceptable documents include: Itemized statements for services, copy of provider billing form, Superbill, or Claim form.

Cash register receipts are not acceptable.

Member's Identification Number: _____

Member's Name: (print)

Last _____ First _____

Member's Address: Street (P.O. Box) _____

City _____ State _____ Zip _____

Telephone Number: _____

The patient is: (check one) ☐ Primary Member ☐ Family Member

If the patient is a family member:

Patient's Name:

Last _____ First _____

Relationship to Policy Holder: _____

Patient's birthdate: Month _____ Day _____ Year _____

Does the patient have other health coverage?

☐ No ☐ Yes, please provide:

Name of other insurance company: _____

Social security number of patient: _____

Effective date of coverage: Month _____ Day _____ Year _____

Type of coverage: ☐ Medical ☐ Dental ☐ Vision

If the patient is a child, give legal guardian's birthdate(s):

Legal Guardian: Month _____ Day _____ Year _____

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Is treatment for an injury? ☐ No ☐ Yes, please provide:

Date of Injury: Month _____ Day _____ Year _____

Where did the injury occur? ☐ Work ☐ Home ☐ School ☐ Other

Briefly describe how injury occured:

_____

_____

_____

Are you seeking reimbursement for the injury or illness through an attorney? ☐ No ☐ Yes

Name of Attorney _____

Address _____ Phone _____

Payment for the attached bills should be made to:

☐ The provider listed on the bill ☐ The member

Please note, when submitting this form to Sovereign Nations Insurance, you authorize the service provider named in the attached bills to release medical and other information to Sovereign Nations Insurance as needed to receive medical records and verify plan coverage.

Member Signature _____

Date _____

Submit completed form & itemized statements to:

Sovereign Nations Insurance
Attn: Claims
P.O. Box 1810
Draper, UT 84020
or
Fax to 801-274-8900

An Important Note about Reimbursements: Reimbursement requests are processed similar to a claim form being submitted by the provider. This means that reimbursements will be processed in accordance with the Plan Document. If your provider is out of network, this may result in a reimbursement amount that is lower than the amount you paid for the medical service.