Meal Therapy Reimbursement

Employees:

1. Please complete items 1 through 14 in full.
2. Please complete items 8 through 11 only if you have other medical coverage, including Medicare.
3. Please be sure to sign the authorization so we can release information on items 12 and 13 if necessary.
4. If you have submitted a request for benefits under another health plan (including Medicare), please attach a copy of the bills you sent to the other plan and the Explanation of Benefits form the plan sent to you.
5. Attach itemized bills or ask your health care provider to complete the applicable section. The bills must include:
   a. Patient's name
   b. Date(s) of service
   c. Condition being treated
   d. Relationship to employee
   e. Type of service(s) given

   If any of this information missing, simply write it on the bill and sign your name.
6. Keep copies of your bills for your records.
7. The mailing address for claims in on the back of your ID card. HealthSCOPE Benefits; P.O. Box 91603; Lubbock, TX 79490

Nevada PUBLIC EMPLOYEES' BENEFITS PROGRAM PEBP Health Matters.

HealthSCOPE BENEFITS

Employee/Patient Information

1. Employee's SSN
Group Number
NVPEB
2. Patient's Name (Last, First, Middle)
3. Patient's Date of Birth Gender
☐ M ☐ F
4. Employee's Name (Last, First, Middle)

5. Patient's Address	
City	
State/Zip	
6. Patient's Relationship to Employee	
☐ Self ☐ Spouse ☐ Child ☐ Other	

7. Employee's Address	
City	
State/Zip	
8. Patient Status	
☐ Single ☐ Married ☐ Other	
Employed?	☐ Yes ☐ No
Full Time Student?	☐ Yes ☐ No
Part Time Student?	☐ Yes ☐ No
9. Employee's Policy/Group No.	
a. Employee's Date of Birth	
b. Claims Administrator	
HealthSCOPE Benefits P. O. Box 91603 Lubbock, TX 79490-1603 email: pebp@healthscopebenefits.com www.healthscopebenefits.com	

10. Patient's or Authorized Person's Signature
I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
Signed
Date
11. Total Charge
12. Amount Paid
13. Supplier Billing Address:
City
State/Zip

14.	A		B	C
	Dates of Services **To**	**From**	**Service or Supply**	Charges
1				
2				
3				
4				