Claim Reimbursement Form

EMPLOYER INFORMATION

Employer Name:

MEMBER INFORMATION (as on your healthcare card)

Covered Employee *(not dependent)*

Name: Member Number:

Group Number:

PATIENT'S INFORMATION

Is patient a dependent? ☐ Yes ☐ No

Patients Name:

DOCUMENTATION

1. An original itemized legible invoice/receipt must be included with this form. Receipt must include diagnosis and procedure codes.
2. Please keep a copy of this form and any supporting documentation for your records.

ADDITIONAL INFORMATION

Please indicate below any additional information that may be helpful in processing your request

SUBMIT

Mail:

WebTPA
An AmWINS Group Company

P.O. Box 1928
Grapevine, TX 76099-9706

Fax:

SHARP Plan:
(469) 417-1960

QUESTIONS

Please call Member Services with the phone number that is on your healthcare ID card.

Reimbursement for claims will be processed according to the benefits outlined in the **Summary Plan** document.

Payment will be made to the member.