aither health

trust built through transparency

ah!

Member Reimbursement Form

1. *Complete this form and check list to request reimbursement when a provider bills you directly for a covered service.*
2. *Requests must be submitted within 12 months of the date of service.*
3. *Complete one form per family member and one form per claim.*
4. *Keep copy of all receipts and documents for records.*
5. *Please email this form & documentation to* ***reimbursement@aitherhealth.com***
6. *For questions, please contact Aither Health at 833-408-4080.*

A. Patient and Subscriber Information

Patient Name:	Patient Date of Birth:
Member ID	

B. Provider or Hospital Information *(This section must be filled out in order to be reimbursed)*

Providers Name:	Providers Phone Number:
Providers Tax Id:	Providers NPI:
Facility Name:	Facility Phone Number:
Facility Tax Id:	Facility NPI:

C. Type of Service *(This section must be filled out in order to be reimbursed)* Date of Service:

CPT Code:	Billed Charge:
CPT Code:	Billed Charge:
CPT Code:	Billed Charge:
CPT Code:	Billed Charge:
CPT Code:	Billed Charge:

D. Reason for Visit *(This section must be filled out in order to be reimbursed)*

ICD 10 Diagnosis Code:___________

E. Form must be signed. Claim can't be processed without member's signature.

Members Signature: ___________________________
Date: