ascend
TO WHOLENESS HEALTHCARE PLANS

DENTAL, VISION, ALTERNATIVE THERAPIES, AND MEDICAL

Claims Reimbursement Form

EMPLOYER INFORMATION

Employer Name:

MEMBER INFORMATION (as on your benefit card)

Covered Employee *(not dependent)*

Name: Member Number:

Group Number: ☐ ARM – Accelerate ☐ ARM – Access

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 99906
Grapevine, TX 76099-9706

Fax:

(469) 417-1960

QUESTIONS

Please call member services at **888-276-4732**

Reimbursement for claims will be processed according to the benefits outlined in the ***Summary Plan*** document, which can be found at **AscendToWholeness.org**.

Payment will be made to the member.