CompleteCare Claim Form

EMPLOYER INFORMATION

REEP School District:

SEND THIS FORM, COPIES OF RECEIPTS, EXPLANATION OF BENEFITS & ANY OTHER CLAIM DOCUMENTATION TO:

Catilize Health
2605 Nicholson Road, Suite 1140
Sewickley, PA 15143

Email: completecare@catilizehealth.com
Telephone: 877-872-4232
Toll Free Fax: 877-599-3724

OR CLAIMS MAY BE SUBMITTED AT PORTAL.CATILIZE.COM

PARTICIPANT INFORMATION

Employee Name:	Last 4 of Social Security No:	Date of Birth:

PRESCRIPTION REIMBURSEMENT INFORMATION:

Date:	Name of Drug:	Co-Pay Amount:
Date:	Name of Drug:	Co-Pay Amount:
Date:	Name of Drug:	Co-Pay Amount:
Date:	Name of Drug:	Co-Pay Amount:
Date:	Name of Drug:	Co-Pay Amount:
Date:	Name of Drug:	Co-Pay Amount:
Date:	Name of Drug:	Co-Pay Amount:
Date:	Name of Drug:	Co-Pay Amount:

PHYSICIAN OFFICE VISITS:

Date of Visit:	Co-Pay Amount:
Date of Visit:	Co-Pay Amount:
Date of Visit:	Co-Pay Amount:
Date of Visit:	Co-Pay Amount:

EXPLANATION OF BENEFITS: EOBs

Date of Service:	Amount Owed:
Date of Service:	Amount Owed:
Date of Service:	Amount Owed:
Date of Service:	Amount Owed:
Date of Service:	Amount Owed:
Date of Service:	Amount Owed:
Date of Service:	Amount Owed:
Date of Service:	Amount Owed:

Documentation submitted must include: Patient name, date of service, type of service or service code, drug name or Rx number if prescription.

Please Note: *All medical claims must be submitted first through your alternate coverage. You are required to include the following documentation: for co-pay, co-insurance or deductible, you will need to submit the Explanation of Benefits (EOB) from your alternate group health plan, and for prescriptions, submit the "tab" that includes the name of the drug, date filled, patient's name and co-pay amount. Do not submit a cash register or credit card receipt; these alone are not acceptable as per the IRS regulations.*

EMPLOYEE STATEMENT:

I hereby certify that the information contained on this Reimbursement Claim Form is to the best of my knowledge and belief, true and correct and each item is eligible for reimbursement. I understand that any expenses reimbursed are NOT tax deductible on my individual or joint federal tax return. I understand that I may be prosecuted for fraud for knowingly using health insurance benefits for which I am not eligible. It is MY responsibility to know when I or a family member is no longer eligible for CompleteCare benefits.

I certify that the amounts above have not been reimbursed under any other health care plan or program, federal, state, or government program, worker's compensation, or any other policy of health insurance, and that I will not seek reimbursement under any of the aforementioned plans, including an HSA, HRA or FSA account.

Employee Signature: _____ **Date:** _____

Claims for plan year 7/1/2023 to 6/30/2024 must be received no later than 90 days after plan year ends or 90 days after termination