



STATE OF ALABAMA

## Public Education Employee Injury Compensation Board



### Provider Medical Reimbursement Information

Medical reimbursement for treatment of work-related injuries sustained by full-time public education employees and adult bus drivers depends on whether the employee is covered by **PEEHIP**.

#### 1. Employees Covered by PEEHIP

For employees enrolled in **PEEHIP**, medical services related to an authorized on-the-job injury should be billed to **PEEHIP**.

The employee should:

- Present their BlueCross BlueShield of Alabama or VIVA Health medical insurance card at the time of service.
- Pay any applicable copayments or deductibles required under their health insurance plan.

All claims for covered medical services should be submitted directly to PEEHIP for payment.

#### 2. Employees Not Covered by PEEHIP

For employees who are not covered by PEEHIP, authorized medical services related to an on-the-job injury are reimbursable through the **Public Education Employee Injury Compensation Board (PEEICB)**. The bill, along with all supporting documentation, should be submitted to Millennium Risk Managers at the address below or emailed to [Bills-PEEICB@mrm-llc.com](mailto:Bills-PEEICB@mrm-llc.com).

Millennium Risk Managers  
c/o PEEICB  
P.O. Box 382408  
Birmingham, AL 35238

If you have any questions, please call Millennium Risk Managers, 205-451-0812.

**PLEASE PROVIDE THIS FORM TO THE DOCTOR'S OFFICE**



## STATE OF ALABAMA

# Public Education Employee Injury Compensation Board (PEEICB)



## COPAY & DEDUCTIBLE REIMBURSEMENT REQUEST

SUBMIT COMPLETED FORM TO:

Millennium Risk Managers

c/o PEEICB

P.O. Box 382408

Birmingham, AL 35238

Email to: [PEEICB@mrm-llc.com](mailto:PEEICB@mrm-llc.com)

Fax: 205-777-6097

Health Insurance Coverage: ☐ PEEHIP ☐ VIVA ☐ Other**EMPLOYEE INFORMATION**

EMPLOYEE NAME:

SSN / Employee ID

Mailing Address:

City:

State:

Zip:

Phone Number:

Email:

**EMPLOYER / SCHOOL INFORMATION**

School System/ Employer:

School / Location:

Department/School:

Supervisor Name:

Supervisor Phone:

**INJURY / CLAIM INFORMATION**

Date of injury:

Claim Number:

Have you received payment for this claim from any other source?

☐ Yes ☐ No

If yes, please explain:

**COPAY & DEDUCTIBLE REIMBURSEMENT EXPENSES**

| DATE OF SERVICE<br>(mm/dd/yyyy) | MEDICAL PROVIDER / FACILITY<br>(Doctor, Hospital, Clinic, Therapy, Pharmacy) | PURPOSE OF VISIT | COPAY/ DEDUCTIBLE |
|---------------------------------|------------------------------------------------------------------------------|------------------|-------------------|
| 1.                              |                                                                              |                  |                   |
| 2.                              |                                                                              |                  |                   |
| 3.                              |                                                                              |                  |                   |
| 4.                              |                                                                              |                  |                   |
| 5.                              |                                                                              |                  |                   |
| 6.                              |                                                                              |                  |                   |
| 7.                              |                                                                              |                  |                   |
| 8.                              |                                                                              |                  |                   |

**REQUIRED DOCUMENTATION:**

Please submit receipt of copay or paid deductible.

**REIMBURSEMENT CALCULATIONS**

A. Total Copay Expenses: \_\_\_\_\_

B. Total Deductible Expenses: \_\_\_\_\_

C. Total Reimbursement Request (A+B) \_\_\_\_\_

I certify that the information provided above is true and correct and that these expenses were incurred as a result of treatment for my compensable injury. I have not been reimbursed for these expenses from any other source.

Employee Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**FOR OFFICE USE ONLY**

|                |               |                  |
|----------------|---------------|------------------|
| Date Received: | Claim Number: | Amount Approved: |
| Reviewed By:   | Check Number: | Date Paid:       |
| Comments:      |               | Initials:        |