CRESCENT
HEALTH SOLUTIONS

ALTERNATIVE PLAN CLAIM FORM

Complete the following and return to claims@crescenths.com

EMPLOYER GROUP:_____ SUBMISSION DATE:_____

EMPLOYEE/PATIENT INFO

Employee Name:	
Patient Name:	
Member ID:	
Phone Number:	

Seeking reimbursement for (check one):

☐ **Medical Reimbursement Plan (MRP):** I have deductibles, coinsurance and/or copayments from my other insurance. *Please send the other insurance Explanation of Benefits (EOB) or Pharmacy Receipts.*

☐ **Maxi Plan:** I am enrolled in the Maxi Plan and have prescription copays from using my prescription drug card for reimbursement. *Please send Pharmacy Receipts.*

☐ **Maxi II Plan:** I am enrolled in the Maxi II Plan and have out-of-pocket expenses that my secondary insurance did not pay. *Please send the other insurance Explanation of Benefits (EOB) or Pharmacy Receipts.*

☐ **ACP:** I have out-of-pocket expenses that my primary insurance did not pay. *Please send the other insurance Explanation of Benefits (EOB) or Pharmacy Receipts.*

Date of Service	Claim Amount	Name of Provider/Pharmacy	Phone # of Provider