

MEDICARE SUPPLEMENT REIMBURSEMENT CLAIM FORM

INSTRUCTIONS

1. Complete, date and sign the claim form.
2. Attach all Medicare Explanation of Benefit claim forms to Part One.
3. Send the completed Part One and attachments to the address shown below.
4. Remove and retain Part Two for your records.

Web: www.scibew-neca.org

PART ONE

Web: www.scibew-neca.org

Last Name	First Name	M.I.	Last Four Digits of the Social Security Number				
Street Address – Do Not Use P.O. Box Apt #	City	State	Zip Code	Phone Number			

I. Please complete the information below.

PATIENT INFORMATION			
	PATIENT LAST NAME	PATIENT FIRST NAME	M.I.
Self			
Spouse			

Important: A Medicare EOB must be submitted with this form in order to receive reimbursement

Participant Signature	Date Signed	Spouse Signature	Date Signed
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**RETURN TO ALLIED ADMINISTRATORS
2831 Camino Del Rio South, Suite 311
San Diego, CA 92108-3829
Telephone: (800) 736-0401**

PART TWO (Retiree's Portion) – FOR YOUR RECORDS ONLY

MEDICARE SUPPLEMENT REIMBURSEMENT CLAIM RECEIPT

Please remove the bottom portion of this form for your records

FAMILY INFORMATION AND CLAIM AMOUNT INFORMATION WITH DATES					
	LAST NAME	FIRST NAME	M.I.	TOTAL AMOUNT BILLED	DATE OF SERVICE
Self					
Spouse					

This form is available online at www.scibew-neca.org