

Other Insurance Information:

Are you or any of your family members covered by another health plan? No Yes

If yes, please include Subscriber Name: _____

Name of other health plan: _____

For Pharmacy Charges:

Please attach legible copies of receipts that include the following information:

Fill date, drug name, drug strength, quantity, days supply, prescription number and your cost.

For Services Related to MVA, Work Injury, or Personal Injury:

Were services related to a motor vehicle accident, a work related injury or any form of personal injury?

No Yes

Date of accident: _____

For Services Out of Country:

Were services rendered at:

Office/Clinic Emergency Room Urgent Care

Pharmacy Inpatient/Outpatient Hospital

Country where treatment occurred: _____

Please explain injury or illness: _____

Please submit all itemized receipts, proof of payment and Explanation of Benefits along with the claim(s) form to:

Alliant, Options & Group Health Processing
P. O. Box 34585
Seattle, WA 98124-1585

Questions?

Please contact our Customer Services Center at 1-888-901-4636 (TTY 1-800-833-6388); 8:00 am - 5:30 pm Monday through Friday. Medicare members, please call 1-888-901-4600; 8:00 am - 5:30 pm Monday through Friday.