Claim Form

Healthy Lifestyle Reimbursement

GROUP NAME City of Sparks GROUP # 327501

HOW TO PRESENT A CLAIM

1. Complete the "Member Information" and "Dependent Information" if benefit is for dependent.
2. Describe what the reimbursement is for in the "Remarks" box.
3. Attach proof of payment to the claim form.
4. Email, fax, mail, or hand deliver the claim form to Hometown Health.

WHERE TO SEND A CLAIM

Hometown Health
10315 Professional Circle
Reno, NV 89521

Fax: 775-982-3741

Email: customer_service@hometownhealth.com

MEMBER'S INFORMATION

MEMBER'S NAME			SEX M ☐ F ☐	MEMBER ID NUMBER
Last	First	Middle		

MEMBER'S ADDRESS				DATE OF BIRTH		
Number and Street	City	State	Zip Code	Month	Day	Year

REMARKS:

DEPENDENT INFORMATION Complete only if patient is a dependent spouse or child.

DEPENDENT'S NAME			SEX M ☐ F ☐	MEMBER ID NUMBER
Last	First	Middle		

RELATIONSHIP	DATE OF BIRTH			
☐ Spouse ☐ Child	Month	Day	Year	

The above answers are true and correct to the best of my knowledge. I hereby authorize any physician, surgeon, practitioner or other person, any hospital, including veterans administration or governmental hospital, any medical service organization, any insurance company, or other institution organization to release to each other, any medical or other information acquired, including benefits paid or payable, concerning this or other disabilities. A photostat of this authorization shall be as valid as the original.

Member's Signature Date

Parent's Signature (Parent, if member is a minor) Date