



# Reimbursement Request Form

## INSTRUCTIONS

To process your reimbursement request, this form must be fully completed, signed, and returned with all required documents. You must attach a copy of your receipt that shows the dollar amount of your request, when the service occurred, and when it was paid. Please allow up to 30 days for review and processing after you submit your request for reimbursement.

Please submit to:

Mail: Pinnacle Claims Management, Inc.      Email: [MERP@pinnacletpa.com](mailto:MERP@pinnacletpa.com)  
P.O. Box 2220  
Newport Beach, CA 92658

### EMPLOYEE INFORMATION

Name	Facility	Phone Number
Address		
City	State	Postal Code
Is this a new address? <input type="checkbox"/> Yes <input type="checkbox"/> No		

### EXPENSE INFORMATION (Please see the back of this form for a description of expense types.)

Type of Expense	Patient Name	Date of Service	Health Plan Carrier/ Service Provider	Amount
<input type="checkbox"/> Out Of Pocket Medical Expenses				
<input type="checkbox"/> Out Of Pocket Medical Expenses				
<input type="checkbox"/> Out Of Pocket Medical Expenses				
<input type="checkbox"/> Out Of Pocket Medical Expenses				
<input type="checkbox"/> Out Of Pocket Medical Expenses				
<input type="checkbox"/> Out Of Pocket Medical Expenses				
<input type="checkbox"/> Out Of Pocket Medical Expenses				
Total Expenses:				

### SIGN AND ACKNOWLEDGE


I attest that the information contained in this Request for Reimbursement is true and accurate. I am an eligible participant in the WSP program, enrolled in a health plan, and seeking reimbursement for a medical health care service covered under my health plan. I understand that if I provide incomplete, false or misleading information, my Request for Reimbursement may be delayed or denied. I agree to indemnify and hold Pinnacle Claims Management, Inc. harmless from any liability for payment of benefits made based upon any of information that is inaccurate or false and to repay any benefits that I incorrectly received.

Signature	Date (mm/dd/yyyy)
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### ACCEPTABLE RECEIPT CRITERIA

1. Patient name must be listed to associate the document with person seeking reimbursement.
2. Date of service must be listed and in the current plan year
3. Patient responsibility (copay, coinsurance, deductible)/goods purchased (Rx, medical equipment, etc.) must be listed on the documentation/receipt, and dated in the current plan year
4. If an Explanation of Benefits (EOB) is provided, it must also include the name of person receiving goods/services

#### Example:

	<b>1</b> Patient Name: <b>JANE DOE</b> Guarantor Name: <b>JANE DOE</b> Guarantor Account #: <b>0123465789</b> Bill Date: <b>08/07/23</b>
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<b>Laboratory/Pathology</b>	
<b>2</b> <b>Date of Service</b> 05/01/23 <b>Provider:</b> R SMITH MD, LABORATORY MEDICINE	<u>Insurance Remarks</u>
Charges \$197.00	A,
Patient Payments 0.00	
Insurance Payments/Adjustments -74.60	
<b>3</b> Amount You Will Need To Pay <b>\$ 122.40</b>	
<u>Insurance Remarks</u> A-Deductible Amount	

### REIMBURSABLE EXPENSE TYPE

#### Out-of-Pocket Medical Expenses:

Your share of medical costs after your Health Plan pays its portion of expenses. Out-of-pocket costs include coinsurance, copayments, and deductibles. This amount will never include an amount that exceeds the covered charge for out-of-network providers (also called "balance-billed charges") or health care expenses that aren't covered on your health plan.