Please fill out, sign, and mail this form with original receipts to:

Lasso Healthcare MSA
303 W. Madison St. Ste. 800
Chicago, IL 60606-3389

Member Claim Submission Form

This form is used when payment was made directly to your provider. We'll determine if the amount you paid was within the Medicare-approved amount and apply the appropriate amount toward your plan deductible. If you've met your deductible, we'll reimburse you the Medicare-approved amount. Once we process your claim, we will send you an Explanation of Benefits (EOB) explaining the processing of the claim. If you overpaid, you may use the letter to seek reimbursement directly from the provider.

Member ID: (found on your Lasso Healthcare ID card)			
First Name:	Last Name:		
Street Address:			
City:	State:	ZIP Code:	
Date of Birth:	Phone Number:	Date of Service:	Was this related to an auto accident? Yes ☐ No ☐
Was this work related? Yes ☐ No ☐	Other Health Insurance? Yes ☐ No ☐		
Name of other Health Insurance:	Policy Number:		

In order to process your request, please:

- Complete one form for each service
- Mail original itemized bill that includes the following:
  - Date of service
  - Charge
  - Amount paid
  - Procedure description and/or code*
  - Diagnosis description and/or code*

  *Doesn't apply for flu shots
- Please keep a copy of your original bill for your files

I certify the above information is true, and the enclosed material is correct and unaltered.

Signature:	Date:

Claims may be denied if received more than one year from the date of service.