Member Reimbursement Form

This form is used when payment was made directly to your provider.
Please fill out, sign, and mail this form with original receipts to:

Lasso Healthcare MSA
P.O. Box 261113
Plano, TX 75026

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
  - 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:

Lasso Healthcare is an MSA plan with a Medicare contract. Enrollment in Lasso Healthcare depends on contract renewal.

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