# Tunica-Biloxi Member Reimbursement Form

Please print clearly, complete all applicable sections and sign.
***Proof of payment is required.***

Submit all documents to:
Advantek Benefit Administrators
Attn: Claims Department
PO Box 45007
Fresno, CA 93718
Or Email: claims@advantekbenefit.com

## Section 1: Member Information

| Member ID Number: | Member Name (Last, First): | Date of Birth: | Phone: |
|---|---|---|---|
| | | | |

| Home Address: | City: | State: | Zip: |
|---|---|---|---|
| | | | |

## Section 2: Assignment of Benefits

I request that payment of authorized medical benefits is made on my behalf directly to the provider of all service(s) furnished to me. **IF NO, SKIP SECTION 3. IF YES, SECTION 3 IS REQUIRED.**

☐ Yes ☐ No If yes, sign here - **Signature:** X________________________________________

## Section 3: Provider Information – Section 3 only needed if YES was selected in section 2.

| Provider Name: | Provider Tax ID Number (required): | Provider Phone: | |
|---|---|---|---|
| | | | |
| **Provider Address:** | **City:** | **State:** | **Zip:** |
| | | | |

***Use a separate sheet of paper for additional services.***

| Date of Service | Place of Service | Procedure Code or Description | Amount Charged | Amount Paid |
|---|---|---|---|---|
| **EXAMPLE** June 5, 2024 | Provider, Hospital or Pharmacy | Office visit, ER visit, Prescription, Outpatient Surgery, Co-Pay or CPT Code | $375.00 | $20.00 |
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By signing below, I am stating the information above is correct. Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete, or misleading information, may be guilty of a criminal act punishable under law and may be subject to civil penalties.

____________________________ ________________
Tribal Member Signature Date