# AHR Claim Form

Name _____

Address _____

City _____

State _____ Zip _____

Last 4 digits of SS# _____

E-mail _____
*(for same day notification of claim status)*

**Mail or Fax Your Claims to:**

***American Health Resources***
11 North 2nd Avenue
St. Charles, IL 60174

**Phone:** 1-800-570-3757
**Fax:** 1-888-815-3921

**To submit claims online or to view balances and transactions, please log in to your account at *www.ahr.net***

*****ATTENTION*****-*Please check the boxes below if you are updating any of the following:*

- ☐ Mailing Address
- ☐ Email Address
- ☐ Direct Deposit (ACH) Acct/Routing #'s
- ☐ Name Change

***Please indicate the account to be used for processing your claim.**

- ☐ **HSA** *--no documentation required*
- ☐ **HRA/CHP** *--requires copy of EOB*
- ☐ **BSA** *--no documentation required*
- ☐ **FSA** *--requires receipt, provider bill or EOB*
- ☐ **DCA** *--requires receipt from provider*

**Total Charges**: $_____

**How would you like us to pay your claim?**

- ☐ Reimburse me by check
- ☐ Reimburse me by Direct Deposit (ACH)*
- ☐ Pay provider (provide address below)

**If you have selected ACH please provide:*
Routing # _____
Account # _____
Checking or Savings? _____

Provider Name _____

Address _____

City _____

State _____ Zip _____

Provider Account # _____

Patient Name: _____

Relationship: _____

Account Holder Signature:

_____

**Participant Attests:**

1 This payment request is for an eligible expense as defined by your benefits plan.
2 This service has not been covered or paid by any other benefit plan.
3 The attached explanation of benefits (EOBs) or bills have not previously been submitted.
4 I certify to the best of my knowledge this claim is true and correct and that I have not received coverage for these charges from any other source.

Revised: 09/2015