



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.**

- | | |
|---|--|
| <input type="checkbox"/> HSA --no documentation required | <input type="checkbox"/> FSA --requires receipt, provider bill or EOB |
| <input type="checkbox"/> HRA/CHP --requires copy of EOB | <input type="checkbox"/> DCA --requires receipt from provider |
| <input type="checkbox"/> BSA --no documentation required | |

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 _____

Patient Name: _____

Address _____

Relationship: _____

City _____

State _____ Zip _____

Account Holder Signature: _____

Provider Account # _____

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.