Sankaty Claims Administration/ACI Inc.
P.O. Box 4000
Collegeville, PA 19426-9000

Call: 1-800-964-7096
Email: Claims@Sankatylight.com
Web: http://secure.visit-aci.com/ClaimStatus/Sankaty
Fax: 1-610-293-9299

SANKATY LIGHT BENEFITS HEALTHCARE COSTS REIMBURSEMENT FORM

FILING INSTRUCTIONS

1. Complete all items below including your signature and date. All the information is essential for prompt and accurate processing of your claim(s). Please do not highlight information or use red ink.
2. You must use a separate claim form for each patient and each calendar year. All expenses for one patient can be submitted with one claim form.
3. Attach an itemized statement of services from the health care provider to your completed claim form and submit to the address above.
4. The itemized statement must include name of patient, date(s} of service, type of services performed, diagnosis and charge(s).
5. An Explanation of Benefits from your base health plan is required for all medical expense claims.

NOTE: SUBMIT A COPY TO SANKATY CLAIMS ADMINISTRATION/ACI NC. AS PER THE ABOVE INSTRUCTIONS AND RETAIN THE ORIGINAL FOR YOUR RECORDS

Employee Name____

Employee Member ID ____

Employee Social Security Number______________________________

Employee Date of Birth (mm/dd/YYYY) ___________________________

Patient Name (one per form) ___________________________________

Patient Member ID ____

Patients' Date of Birth (mm/dd/YYYY) ___________________________

Patient Relation to Employee: __ Self; __Spouse; __ Child; __ Other

*****Explanation of Benefits is Required for all medical expenses*****

Type of Service Please place and "x" in the appropriate box								Provider Name	Date of Service	Amount Requested for Payment by Sankaty Light Benefits
M	D	ORTHO	V	L	Rx	OTC	O			

Medical, **D**ental, **Ortho**dontia, **V**ision, **L**asik, **R**x (prescription), **O**ver **the C**ounter, Other (Please detail)

TOTAL_______________

I certify that this information is true and correct to the best of my knowledge, that I am requesting reimbursement only for eligible expenses that have actually been incurred, and that the submitted expenses are not payable by any other insurance or health care expense prepayment or reimbursement plan.

Employee's Signature____ Date__________________

TO BE COMPLETED BY EMPLOYER

IMPORTANT – Employer Group Name ______________________________Tax ID__________ Employer Address/Number/Street __________________ ______________________________, City_________ State,___ Zip code______. Employer Policy Number ______________________________

I hereby certify that I have read the Employee's Statement of this claim for Medical Reimbursement Insurance Benefits and to the best of my knowledge and belief, each representation to be true and correct, and each item of expense to be eligible for reimbursement. I recommend and endorse payment in full of the balance shown in the column labelled "Amount Eligible for Payment".

Signature and title of Corporate officer_____________________________________ Date__________________