ALASKA ELECTRICAL HEALTH & WELFARE PLAN
701 E. Tudor, Suite 200
Anchorage, AK 99503
aetfhw@aetf.com
(907) 276-1246
Toll Free: (800) 478-1246

Medical/Dental Reimbursement Request

If your provider does not bill insurance directly please use this form to request reimbursement and attach all supporting documentation.

PARTICIPANT INFORMATION

Employee Full Name _____ Medical ID# _____

Contact Phone _____

Patient's Name _____

PROVIDER INFORMATION

Provider Name _____

Provider Mailing Address _____ City _____ State _____ Zip Code _____

Provider Telephone _____ Provider Tax ID _____

In order to reimburse you for services the receipt or superbill must have the following:

- Date of service
- Patients name
- Zero Balance and/or receipt as proof of payment
- Current Medical procedural code (CPT) example: 99214
- Current Dental Code (ADA)
- Medical Diagnosis Code (ICD-10)

Please be advised the payment will be sent to the address on file.

If you have further questions please call the Administrative Office.

In order to receive payment for your claims, you must maintain a current Annual Medical/Dental Update form for you and each of your eligible Dependents.

If you or your dependent have other coverage that is primary, please be sure to also attach a copy of the Primary Insurance Explanation of Benefits.

Please allow up to 30 days for processing.