Number of pages including this cover sheet _____

nonstop™

Claim/Reimbursement Request Form

Employer Name

Employee Information

Last Name	First Name	Middle Initial
Home Address	City / State	Zip Code
Phone	Email	Date of Birth

REQUIRED FOR CLAIM SUBMISSION:

1. **Complete this Claim Form**. Sign and date.
2. **Required Documentation -** Please provide **all** necessary documentation.
   - **For payment to a medical provider.** Submit all pages of (a) the medical insurance carrier EOB, **and** (b) the service provider bill showing the account number and where payment should be sent, **and** (c) this form.
   - **Reimbursement for payment(s) to a medical provider/service**. Submit all pages of (a) the medical insurance carrier EOB **or** remittance report, **and** (b) proof of payment, **and** (c) this completed claim form.
   - **Reimbursement for payment for a prescription.** Submit (a) a receipt from the pharmacy, **and** (b) the prescription bag receipt/pharmacy printout (showing the member's name, the name of the prescription, and that your medical insurance carrier processed the prescription), **and** (c) this completed claim form.
3. Submit this completed form with the required documentation through the Nonstop Exchange (NSE) member portal (members.nonstophealth.com), or:
   - **Nonstop Health Claims**:
     - Email: claims@nonstophealth.com
     - Mailing address: 1800 Sutter St. Suite 730 Concord CA 94520
     - Fax: 877.463.1175

CHECK THE APPLICABLE BOX:

☐ **I have paid. Send the reimbursement check to me.** (The check will be mailed to the address in our system.)

☐ **I have not paid. Send payment to the provider.** (Include **all pages** from the provider bill.)

Date of Service	Type of Expense	Name of Member or Dependent	Requested Amount
		Total Reimbursement Requested	

The undersigned participant in the plan certifies that all expenses for which reimbursement or payment is claimed by submission of this form, were incurred during a period while the undersigned was covered under the plan with respect to such expenses; and that such expenses have not been reimbursed, or are not reimbursable, under any other benefit plan coverage. The undersigned fully understands that he or she alone is responsible for the sufficiency, accuracy, and veracity of all information relating to this claim which is provided by the undersigned, and that unless an expense for which payment or reimbursement is claimed is a proper expense under the plan, the undersigned may be liable for the payment of all related taxes including federal, state, or city income tax on amounts paid from the plan which relate to such expense.

Signature _____ Date _____