Number of pages including this cover sheet _____

nonstop™

Claims / Reimbursement Request Form

Company Name

Employee Information ☐ Check here if any contact information is new

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

ITEMS REQUIRED FOR SUBMITTING THIS FORM:

1. Please fill out the form completely. Complete all pertinent information in the spaces provided. Sign, date & return to Nonstop Health Claims via fax (877.463.1175) or via mail at 1800 Sutter Street, Suite 730, Concord, CA 94520, or email (claims@nonstophealth.com).
2. For payment to a medical provider or reimbursement of medical services to a member. Please include:
   a. EOB from medical insurance carrier
   b. Bill from provider of service
3. For reimbursement to member for a pharmacy purchase, please include:
   a. Receipt from cash register at pharmacy
   b. Bag/prescription receipt with name of member and name of prescription

CHECK THE APPLICABLE BOX BELOW:

☐ I have not paid. Send payment to provider. **☐ I have paid. Send reimbursement check to me.**

Date of Service	Type of Expense	Name of Member or Dependent	Requested Amount
		Total Reimbursement Requested	0

Provider's Name	Phone Number
Mailing Address	City/State/Zip

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

SUBMIT TO NONSTOP HEALTH CLAIMS
1800 Sutter St., Ste. 730, Concord, CA 94520
Phone: 877-626-6057 • Fax: 877-463-1175
Email: claims@nonstophealth.com