SERVICE PROVIDER CLAIMS FORM

PLEASE NOTE: All claims from the previous calendar year are not eligible for reimbursement after April 1st of the next calendar year.

Number of pages including this cover sheet _____ **Date submitted** _____

EMPLOYEE INFORMATION		
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 Wellness Claims via fax (877.463.1175) or via mail at 1800 Sutter Street, Suite 730, Concord, CA 94520, or email (claims@nonstopwellness.com).
2) Attach an itemized Explanation of Benefits (EOB) and bill or HIFC
3) EOB MUST INCLUDE: Date of service, description of service, amount patient is responsible for, clearly listed carrier adjustments, and remarks codes with an explanation of each code.

All pages MUST be included in order for claim to be processed.

Date of Service	Type of Service	Name of Member or Dep	Patient's Responsibility
		Total Payment Requested	

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

SUBMIT TO NONSTOP WELLNESS CLAIMS
1800 Sutter Street, Suite 730, Concord, CA 94520
Phone: 877-626-6057 // Fax: 877-463-1175
Email: claims@nonstopwellness.com