Implant Reimbursement Request Form

Please complete the following fields and fax to 215-238-7088.

Provider name: _____

Provider #: _____

Member name: _____

Member ID #: _____

Member provider account #: _____

Surgical paid claim #: _____

Admit date: _____

Discharge date: _____

Implant type: _____

Implant invoice cost: _____