Member Claim Submission Form

Send this claim to: **Advantek Benefit Administrators, P.O. Box 45007, Fresno, CA 93718**

This form is to be used only when the provider of service does not submit your claim directly to Advantek.
Check with the provider to be sure no claim has been submitted.
Duplicate claims will not only be rejected but may delay payment of the original claim.

Please fill out the form below and attach any documentation you have from your service provider.

Member Information Please tell us who this claim is for. If not for you, please enter the member's name and ID number.	
Member Name (Last, First, Middle)	
Member ID Number or **Social Security Number**	
Claim Number or **Date of Service**	
Billed Amount	

Provider Information	
Provider Name	
If you know it, please enter the **Provider Number** or **Tax ID Number**	

Contact Information In the event we have questions, please enter a name and contact information where we may reach you.	
Contact Name	
Contact Phone	
E-mail	

Additional Details Please describe the services you received plus any additional information that might be helpful in processing your request.

Subscriber's signature

I certify that the foregoing information is accurate and complete, and authorize the release of any medical information to process this claim.

X_____ Date_____