Tunica-Biloxi Member Reimbursement Form

Please print clearly, complete all applicable sections and sign.
Proof of payment is required.

Submit all documents to:
Advantek Benefit Administrators
Attn: Claims Department
PO Box 45007
Fresno, CA 93718
Or Email: claims@advantekbenefit.com

Section 1: Member Information

Member ID Number:	Member Name (Last, First):	Date of Birth:	Phone:	
Home Address:	City:		State:	Zip:

Section 2: Assignment of Benefits

I request that payment of authorized medical benefits is made on my behalf directly to the provider of all service(s) furnished to me. **IF NO, SKIP SECTION 3. IF YES, SECTION 3 IS REQUIRED.**

☐ Yes ☐ No If yes, sign here - **Signature:** X_____

Section 3: Provider Information – Section 3 only needed if YES was selected in section 2.

Provider Name:	Provider Tax ID Number (required):	Provider Phone:	
Provider Address:	City:	State:	Zip:

Use a separate sheet of paper for additional services.

Date of Service	Place of Service	Procedure Code or Description	Amount Charged	Amount Paid
EXAMPLE June 5, 2024	Provider, Hospital or Pharmacy	Office visit, ER visit, Prescription, Outpatient Surgery, Co-Pay or CPT Code	$375.00	$20.00

By signing below, I am stating the information above is correct. Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete, or misleading information, may be guilty of a criminal act punishable under law and may be subject to civil penalties.

Tribal Member Signature _____ Date _____