CONSOCIATE HEALTH

Claims Submission for Medical Reimbursement Plan (MRP)

Send information to:

P.O. Box 1068
Decatur, Illinois 62525
800.798.2422 (toll free)
217.423.4575 (fax)
or scan and email to:
customerservice@consociate.com

Medical Reimbursement Plan Claim Form

Date of Request: _____

Employee Name: _____

Employer Name: _____

Dependent Name if Claim is for Dependent: _____

Employee/Dependent ID Number: _____

Phone Number where Member can be reached: _____

Please attach the explanation of benefits (EOB) from the primary insurance company.
If an EOB is not provided, you may also submit an itemized receipt or invoice from the provider

Please mail, fax or email claims as indicated above..