Cape Girardeau School Health Care Plan

# Alternative Plan Claim Form

Please fill out as much information as possible and **fax to Mutual Medical at 309-674-5420**.

Employee Name: _____ Employee Phone Number: _____

Patient Name: _____ Number of Attached Pages: _____

Member ID: _____ Date of Fax: _____

Seeking Reimbursement for: (check one)

_____ Medical Reimbursement Plan (MRP) – *I have deductibles, coinsurance and/or copayments from my other insurance.* **Please send the other insurance's Explanation of Benefits (EOB), or Pharmacy Receipt.**

_____ Maxi Plan – *I am enrolled in Maxi Plan and have Rx copays from using my Prescription Drug card for reimbursement.* **Please send Pharmacy Receipts.**

_____ Maxi II Plan – *I am enrolled in the Maxi II Plan and have out-of-pocket expenses that my secondary insurance did not pay.* **Please send the other insurance's Explanation of Benefits (EOB), or Pharmacy Receipt.**

_____ ACP – *I have out-of-pocket expenses that my Primary Insurance did not pay.* **Please send the other insurance's Explanation of Benefits (EOB), or Pharmacy Receipt.**

| Date of Service | Name of Provider/Pharmacy | Phone # of Provider |
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