KERN LEGACY Network Plus
EXCLUSIVE NETWORK HEALTH PLAN

KERN LEGACY HEALTH PLANS

Employee & Retiree Medical Plan Options

KERN LEGACY Share Select
HIGH-DEDUCTIBLE EPO HEALTH PLAN

1115 TRUXTUN AVE, 1ST FLOOR | BAKERSFIELD CA 93301 | PH: 661 868-3280 | FAX: 661 868-3295 | WWW.KERNLEGACYHP.COM

Member Request for Medical Reimbursement

Complete this form and return if you paid out-of-pocket for expenses that may be covered by the Plan. Your request will be reviewed and processed by the Claims Administrator, HealthEdge. Submission of a request does not guarantee payment. Most requests are processed within 30 days. If reimbursement is approved, a check will be sent to the Plan Subscriber at the address listed in the system.

Section A: Subscriber information *(the Employee or Retiree)*	
Subscriber Name:	
Subscriber ID:	Subscriber Phone:
Section B: Patient Information *(covered member that received medical services or supplies)*	
Patient Name:	Date of Birth:
Member ID:	Patient Phone (if over 18 yrs. old):
Section C: Provider Information *(physician and/or facility that provided care to the patient)*	
Physician Name:	Facility Name:
Provider Phone:	Is the Provider located out of Kern County? ◯ Yes ◯ No
Provider Address:	City/State/Zip:

Section D: Service Information.		
Date of Service:	Total Charges:	Member Paid:
Service or Supply Provided:		

Section E: Authorization to Release Information.

I, _____ authorize the release of any medical or other information necessary to process this claim.

Patient or Authorized Representative

Signature: _____ **Date:** _____

Please mail completed form and receipt or other proof of service and payment attached to:
HealthEdge Administrators - Member Reimbursement P.O. Box 11210, Bakersfield CA 93389
You can also Fax the form and documentation to: (661) 616-48450

Print Clear Form

Revised December 7, 2018