



Please fill out, sign, and mail this form with original receipts to:

Zing Health
225 West Washington St. Suite 450
Chicago, IL 60606

**Direct Member Reimbursement Form
PPO Out of Network Supplemental Benefit Services**

This form is used when payment was made directly to your vendor for plan supplemental benefits. We'll determine if the amount you paid was within your Plan-approved benefit coverage amount and apply the appropriate amount toward your plan cost sharing. If approved, we'll reimburse you the plan-covered amount. Once we process your request, we will send you check to the address provided.

Member ID (Found on Zing ID card)

Phone Number

First Name

Last Name

Mailing Address

City

State

Zip

Date of Service

Benefit Type:

Hearing Services

Fitness (gym access)

In-Home Support Services

Meals: Post Discharge Meals

Nurse Advice Line

I certify the above information is true, and the enclosed material is correct and unaltered.

Signature _____

Date _____

Provide a copy of an itemized receipt showing services rendered, charge(s), payment, and date of service along with this form. Retain copies for your own records. Zing Health will review your submission and make a coverage determination. You will be notified no later than 60 days from receipt of the request.

*Note: Request may be denied if received more than one year from the date of service