T: 855.373.8232
F: 360.746.8386
PO Box 3070
Bellingham, WA 98227
www.casbenefits.com

CLAIM REIMBURSEMENT FORM

Employer: ______________________________
Employee Name: __________________________
Claimant Name: __________________________
Claimant ID Number: _______________________

Keep your original documents. Please include a copy of the receipt/invoice for each transaction where reimbursement is requested. All Reimbursements are paid to the employee regardless of who the patient is. Submit completed documentation to **customerservice@casbenefits.com / fax: (360)746-8386**
To find an in-network provider, please go to www.casbenefits.com.

	Date of Service	Provider Full Name and provider type (e.g. MD, PA, LCPC)	Provider Tax ID or NPI	Service Description or CPT Code	Diagnosis or ICD-10 DX Code	Amount Paid
1						
2						
3						
4						
5						
6						

Signature: ______________________ Date: ______________________

Claims Department