How to file a claim / reimbursement

The Nonstop Wellness plan is designed so that your employer pays your deductible for you. In order for the deductible to be paid you must file a claim through Nonstop.

#1 You will receive a bill from your service provider (Doctor visit, lab work, x-ray, etc.) and an Explanation of Benefits (EOB) from your medical carrier. We need both to effectively process your claim. Check with your carrier - generally you can download your EOBs online if you have not yet received it in the mail or need a replacement.

Or

If, you pay for a service or prescription out of pocket, you will need your receipt showing payment, date of service and type of service provided and for prescriptions we need the medication receipt attached to the prescription bag with your proof of payment.

Note: You cannot be reimbursed if you pay using your health care or flex care spending account, it is against IRS rules.

#2 Complete the claims / reimbursement form. Additional forms can be found at www.nonstopwellness.com/support .

#3 Take the claims / reimbursement form and **ALL** pages of the bill and EOB and **send to only 1 of the following**:

Fax: 877-463-1175

or

E-mail: claims@nonstopwellness.com

or

Mail: 555 W. Shaw Ave
Suite C-1
Fresno, CA 93704

It will take 7 to 10 business days for a check to mail out. If a claim is approved or denied you will be notified by mail.

If you have questions, please call us at 1-877-626-6057

Note: It could take 30 to 45 days for a large service provider to post the payment to your account. You may receive another bill in the mail before the post.

nonstop WELLNESS

CLAIM / REIMBURSEMENT REQUEST FORM

Number of pages including this cover sheet _____ **Date submitted** _____

EMPLOYER NAME	

EMPLOYEE INFORMATION		☐ **Check here if any contact information is new**
Last Name	First Name	Middle Initial
Home Address	City/ State	Zip Code
Phone	Email	Date of Birth

CHECK THE APPLICABLE BOX BELOW:

☐ I have not paid. Send payment to provider. ☐ I have paid. Send reimbursement check to me.

ITEMS REQUIRED FOR SUBMITTING THIS FORM:

(1) Complete all pertinent information in the spaces provided. Sign, date & return to Nonstop Wellness via fax (877-463-1175) or email (claims@nonstopwellness.com).

(2) Attach an itemized Explanation of Benefits (EOB) or receipt from Insurance Carrier/Provider to support requested reimbursements. For prescription reimbursements both the pharmacy and medication receipts must be included.

(3) EOB/RECEIPT MUST INCLUDE: Date of service, description of expense, cost of expense, amount patient responsible for clearly listed for approval.

All pages MUST be included in order for your reimbursement to be processed.

Date of Expense	Type of Expense	Name of Member or Dependent	Requested Amount
		Total Reimbursement Requested	

Provider's Name	Phone Number
Mailing Address	City/State/Zip

The undersigned participant in the plan certifies that all expenses for which reimbursement or payment is claimed by submission of this form, were incurred during a period while the undersigned was covered under the plan with respect to such expenses; and that such expenses have not been reimbursed, or are not reimbursable, under any other benefit plan coverage. The undersigned fully understands that he or she alone is responsible for the sufficiency, accuracy, and veracity of all information relating to this claim which is provided by the undersigned, and that unless an expense for which payment or reimbursement is claimed is a proper expense under the plan, the undersigned may be liable for the payment of all related taxes including federal, state, or city income tax on amounts paid from the plan which relate to such expense.

_____
SIGNATURE

_____
DATE

SUBMIT TO NONSTOP WELLNESS
555 W. Shaw Avenue, Suite C-1, Fresno CA 93704
Phone: 877-626-6057 // Fax: 877-463-1175
Email: claims@nonstopwellness.com