start™

Start Health Insurance — Simpler. Better. Different.

NOTE: This form is NOT for insurance billing.

Start Health Member Reimbursement Form

Patient Portion

Patient Name: _____ Date of Service: _____

Facility/Provider Name: _____

Facility/Provider Address: _____

Provider Portion

Because our members are self-pay patients, as defined by the No Surprise Act, they need an itemized bill in order to submit an expense for personal reimbursement. Please provide the following details:

Codes	Dx Codes	QTY	Service Description	Charge

Total Paid: _____

Provider Signature: _____

Fax: (888) 253-9040

Main: (800) 894-9454