Destiny Health™

PMF Exception Claim Form

Instructions on how to file a claim:

1. Complete this claim form
2. Attach supporting statements or bills
3. Submit to:

   Destiny Health
   Attn: PMF Exceptions
   PO Box 9219
   Oak Brook, IL 60523

Please retain copies of submissions for your own records

Section A: Subscriber Information

Company Name:	Account #:
Subscriber name:	Subscriber #:

Section B: Claim Information

Patient Name	Relationship	Claim date	Description	Amount to be reimbursed
1.				$
2.				$
3.				$
4.				$
5.				$
6.				$
			TOTAL REIMBURSEMENT REQUEST	**$**

Section C: Certification

I certify that the expenses for which I am requesting reimbursement meet all of the following conditions listed below:

- They were incurred for services or supplies furnished to me or my eligible dependents under the plan.
- They were for services or supplies furnished on or after the effective date.
- I have not been reimbursed for these expenses in any other way.

I understand that reimbursement will be made in accordance with the provisions of the PMF Contract. I accept responsibility for the proper treatment of benefits paid under this plan with respect to eligibility, income tax reporting, and liability.

Subscriber's Signature:	Date:

Please return this form and supporting statements or bills to Destiny Health as indicated above.