Please complete form below and include any relevant documents received from the health care provider at the time of the health care service and proof of payment if applicable.

EMPLOYER (IF APPLICABLE)	GROUP NUMBER
MEMBER'S NAME LAST FIRST MIDDLE INITIAL	MEMBER ID NUMBER
MEMBER'S ADDRESS CITY STATE ZIP CODE	TELEPHONE NUMBER
PATIENT'S NAME DATE OF BIRTH	☐ SELF ☐ SPOUSE ☐ CHILD
ARE YOU, YOUR SPOUSE, AND/OR DEPENDENTS COVERED UNDER ANY OTHER HEALTHCARE POLICY AT THE TIME THE ENCLOSED CLAIM WAS INCURRED? ☐ NO ☐ YES	
IF YES, WHAT IS THE NAME AND ADDRESS OF THE COMPANY AND THE POLICY NUMBER?	
NATURE OF ILLNESS OR INJURY (IF ACCIDENT, STATE WHEN, WHERE AND HOW IT OCCURED)	

COMPLETE THE FOLLOWING DETAILS REGARDING YOUR VISIT

CODING OF THE HEALTH CARE SERVICE	DATE OF THE HEALTH CARE SERVICE	
NAME OF THE HEALTH CARE PROVIDER	PLACE OF SERVICE	BILLED CHARGES

INSURED'S OR AUTHORIZED PERSON'S SIGNATURE

Signed Date

Return to: Aspirus Health Plan
P.O. BOX 1062
Minneapolis, MN 55440

PLEASE SEND THE ORIGINAL BILLS NOT PHOTOCOPIES

If any bills have been paid, please mark them 'PAID.'

Important: Any Person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.