

# Request for Claim Reimbursement

Company Name \_\_\_\_\_

GROUP # \_\_\_\_\_

\_\_\_\_\_  
Employee Name

\_\_\_\_\_  
ID# on insurance card

\_\_\_\_\_  
Patient's Name

\_\_\_\_\_  
Relationship to Employee

**Attach itemized bill or a copy of prescription receipts & mail or fax to:**

**Noridian Benefit Plan Administrators (NBPA)**

P. O. Box 2339  
Fargo, ND 58108

Fax (701) 237-0626

**Please call with any questions:**

**Providers (701) 237-4787**

**Employees (800) 554-3951**

Non Participating Provider Expenses: If you receive medical services from non-participating providers, they are not required to submit charges to NBPA. In the event your provider will not submit your charges directly to NBPA, you will be responsible for claim submissions.

To help identify the employee and patient for any claims being submitted to us, please attach this completed form to your itemized bill and/or receipts. Be sure to make a copy of your receipts and any supporting documentation before sending. NBPA does not need the original to process the claim.