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Supplemental Counseling Benefit Reimbursement Form for Out-of-Pocket Supplemental Counseling Expenses

Employee: The Supplemental Counseling benefit can only be used by participants in the Standard PPO plan with out-of-network providers.

Please attach receipts indicating paid out-of-pocket expenses for the Supplemental Counseling Benefit. Providers must include appropriate diagnostic and insurance (CPT) codes in order for Supplemental Counseling Benefit claims to be processed.

1. Employer's Name: The Texas Annual Conference of The United Methodist Church Group Number: 002928

2. Employee's Name: _____

3. Employee's Address: _____

Provide *one* of the following:

4a. Employee's Boon-Chapman Participant ID No.: _____ *or*

4b. Employee's Social Security No.: _____

5. Patient's Name: _____ Relationship: _____ Birthdate: _____

Please make benefits payable to the Employee above.

Authorization to Release Information:

I hereby authorize the physician/provider to release any information acquired in the course of my or my dependent's examination or treatment. I understand that such information will be used by Boon-Chapman for the purpose of verifying that the services charged for were provided and that my authorized representative or I will receive a copy of this authorization upon request. This authorization is valid from the date signed for the duration of the claim, unless revoked in writing by me or my legal representative. The information I have provided on this form is true and correct to the best of knowledge. I agree that a photographic copy of this authorization shall be as valid as the original.

Signature of Employee

Date