WINFertility Reimbursement Form

Email completed and signed application along with the required documentation and itemized bills/receipts to: WINSpecialtyServices@WIN-Healthcare.com
Or mail to: WINFertility, Inc.
Greenwich American Center
One American Lane, Terrace Level
Greenwich, CT 06831
Attn: Claims Department

MEMBER INFORMATION----------

Member ID: _____ Member Date of Birth:_____

First Name: _____Middle Initial: _____Last: _____

Covered Dependent / Spouse Name:_____Relationship:_____

Home Address: _____

Apt. #: _____City, State, Zip:_____

Home Phone/Cell: _____ Work Phone: _____

EMAIL Address: _____Date of Hire: _____

Employer Name: _____

Physician's Name:_____ Physician's Tel #:_____

Physician's Tax ID #: _____

REIMBURSEMENT EXPENSES----------

Required documentation: Please attach itemized receipts of expenses indicating the amount, date, nature of expense, name of person, name of organization or entity to which the expense was paid. (Please list additional expenses on separate page in a similar format as below if needed)

Date Incurred ***(mm/dd/yyyy)***	**Description of Expenses:**	**Amount**
		$
		$
		$
		$
		$
	Total Requested Reimbursement	$

Applicant Signature: _____ Date:_____

Printed Name: _____