Implant Reimbursement Request Form

Please complete the following fields and fax to **215-761-0922** or email to **provrelations@ahatpa.com**.

Provider name: ______________________________

Provider #: ______________________________

Member name: ______________________________

Member ID #: ______________________________

Member provider account #: ______________________________

Surgical paid claim #: ______________________________

Admit date: ______________________________

Discharge date: ______________________________

Implant type: ______________________________

Implant invoice cost: ______________________________