

DESCHUTES COUNTY
EBMS CLAIM REIMBURSEMENT
FAX COVER

FACSIMILE TRANSMITTAL SHEET

| | |
|--------------------------------------|-------------------------------------|
| TO: CLAIMS | FROM: |
| COMPANY: EBMS | DATE: |
| FAX NUMBER: (406) 652-5380 | TOTAL NO. OF PAGES INCLUDING COVER: |
| PHONE NUMBER: | SENDER'S REFERENCE NUMBER: |

RE: **DESCHUTES COUNTY
EMPLOYEE SUBMISSION OF
CLAIM FOR PROCESSING AND
REIMBURSEMENT**

Employee ID # 999-17-
(# is located on blue card)

Sender Fax #: 541-330-4626

PLEASE REIMBURSE TO: EMPLOYEE PROVIDER
(Circle One)

**EBMS: Please see attached statement/receipt from Provider,
and process for the Member listed below:**

| | |
|---|---------------------------|
| Name of Employee | Name of Patient for Claim |
| Claim Type <i>(Medical/Dental/Vision/Alternative)</i> | Provider Name |
| Date of Service | Billed Amount |

1300 NW WALL SUITE 201
BEND OR 97701
541-617-4722 OFFICE * 541-330-4626 FAX
