Number of pages including this cover sheet _____

nonstop™

Service Provider Claims Form

Employee Information

Last Name	First Name	Middle Initial
Home Address	City / State	Zip Code
Phone	Email	Date of Birth

ITEMS REQUIRED FOR SUBMITTING THIS FORM:

1. Please fill out the form completely. Complete all pertinent information in the spaces provided. Sign, date & return to Nonstop Health Claims via fax (877.463.1175) or via mail at 1800 Sutter Street, Suite 730, Concord, CA 94520, or email (claims@nonstophealth.com).
2. Attach an itemized Explanation of Benefits (EOB) and bill or HIFC
3. EOB MUST INCLUDE: Date of service, description of service, amount patient is responsible for, clearly listed carrier adjustments, and remarks codes with an explanation of each code.

All pages MUST be included in order for claim to be processed.

Date of Service	Type of Expense	Name of Member or Dependent	Patient's Responsibility
		Total Reimbursement Requested	0

Provider's Name	Phone Number
Mailing Address	City/State/Zip

SUBMIT TO NONSTOP HEALTH CLAIMS
1800 Sutter St., Ste. 730, Concord, CA 94520
Phone: 877-626-6057 • Fax: 877-463-1175
Email: claims@nonstophealth.com