DEDUCTIBLE / CO-PAY MAXIMUM CLAIM FORM
ITEMIZED STATEMENT

DATE:
MEMBER NAME :
MEMBER NO. :
MEMBER CONTACT NO:

Please complete the chart below to include all provider visits, services and prescription drugs.
Please attach original receipts, supporting documents and claim forms.

For Office Use Only
Date Received By NetCare:

Provider	Description of Service	Date of Service	Amount Paid		Ex	U$	COPAY	NET
	Total Amount of Receipts Submitted To NetCare:		$		0.00	0.00	0.00	0.00