NetCare
Life & Health Insurance

ANNUAL CO-PAYMENT MAXIMUM CLAIM FORM
ITEMIZED STATEMENT

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

Please complete the chart below to include all particpating provider visits, services and prescription drugs.
Please attach original receipts, supporting documents and claim forms which include CPT & Diagnosis codes.

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**