Northern Light Health

Employee Health Plan Claims Assistance Form

Employee Information:

Employee Name: _____

Contact Number(s) Preference: Home # _____ Cell #_____ Work # _____

Email Address: _____ Claims Issue ☐ HRA Issue ☐

Employee ID Number: _____ Beacon ID Number: _____

Claim #: _____ Date of Service: _____ Provider: _____

Claim #: _____ Date of Service: _____ Provider: _____

Claim #: _____ Date of Service: _____ Provider: _____

Claim #: _____ Date of Service: _____ Provider: _____

Claim #: _____ Date of Service: _____ Provider: _____

Claim #: _____ Date of Service: _____ Provider: _____

Claim #: _____ Date of Service: _____ Provider: _____

Claim #: _____ Date of Service: _____ Provider: _____

Claim #: _____ Date of Service: _____ Provider: _____

Comments: _____

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