SENTRI Pass Reimbursement Form*

MEMBER INFORMATION	
First Name:	Last Name:
Member ID:	Date of Birth: _ _ / _ _ / _ _ _ _
Address/City/State/Zip code:	Employer:
Telephone #: (_ _ _) _ _ _ - _ _ _ _	Alternate Telephone #: (_ _ _) _ _ _ - _ _ _ _

INSTRUCTIONS TO REQUEST REIMBURSEMENT

Please include the following documents along with your COMPLETED reimbursement form:

1. Front and back copy of SENTRI Pass with issued date.
2. Expense receipts for SENTRI Pass.

E-mail required documentation to applications@mediexcel.com **or mail to**

MediExcel Health Plan
Attention: SENTRI Pass Reimbursement
750 Medical Center Ct., Suite 2
Chula Vista, CA 91911

CERTIFICATE OF STATEMENT

I certify that the above information is true and correct, the attached material is unaltered, and the expenses were incurred by the member named above. I understand that all documents submitted become the property of MediExcel Health Plan and will not be returned. I understand that if I submit false receipts or fraudulently altered documents, I may be disenrolled from MediExcel Health Plan and subject to civil or criminal penalties.

California Residents: For your protection, California law requires the following to appear on/with this form. Any person who knowingly presents a false or fraudulent claim for the payment of a reimbursement is guilty of a crime and may be subject to fines and confinement in state prison..

_____ _____

Member Signature **Date**

MediExcel Health Plan Use Only	Date Processed:	Processed by:	Approved by:

**Only active primary health plan subscribers are eligible. Please allow up to three weeks for processing. Reimbursement is for a SENTRI Pass acquired after your MediExcel Health Plan enrollment date. Renewal passes are not eligible. Reimbursement cannot exceed $92 USD and will be mailed to the address listed on the reimbursement form.*

Because your Health is First – MediExcel Health Plan