



SENTRI Pass Reimbursement Program

Our **SENTRI Reimbursement Program just got better!** MediExcel will reimburse **up to 75%** of SENTRI Pass fees for active **Primary** and **Dependent** medical subscribers.

Here is how it works:

1. Download our SENTRI reimbursement form from the MEMBERS tab at www.mediexcel.com.
2. Provide a legible copy of the front and back of your SENTRI Pass with a visible issued date. The issued date must be after your enrollment date in MediExcel Health Plan.
3. Provide a legible copy of your SENTRI Pass fee receipts.

E-mail required documents to applications@mediexcel.com. You may also mail copies of your documents to 750 Medical Center Court, Suite 2, Chula Vista, CA 91911, or visit our Member Enrollment Center at our Chula Vista office and present them in person.*

*Only active primary health plan subscribers and their dependents are eligible. Please allow up to three weeks for processing. Reimbursement is available for a SENTRI Pass (new or renewal) acquired **after** your MediExcel Health Plan enrollment date. **Limit to one reimbursement per person for the lifetime of their membership.** Reimbursement cannot exceed 75% of the cost of a single adult pass. Reimbursement will be mailed to the address listed on the form. MediExcel Health Plan reserves the right to modify or discontinue the SENTRI Pass reimbursement program at any time and for any reason.



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:

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Because your Health is First – MediExcel Health Plan