Spectera
Out-Of-Network Reimbursement Request

Subscriber Name: _____
Subscriber ID#: _____
Subscriber Address: _____
_____

Patient's Name: _____
Patient DOB: _____

Send this form, along with the itemized receipt to:

Spectera Claims Department
PO Box 30978
SLC, UT 84130
-or-
Fax: 248-733-6060