Spectera
Out-Of-Network Reimbursement Request

Subscriber Name: ____________________________
Subscriber ID#: ____________________________
Subscriber Address: ____________________________
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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