INPATIENT HOSPITAL REIMBURSEMENT PLAN – APRIL 2026

EMPLOYEE REQUEST FORM

Today's Date: _____

To: **Horizon House**
Benefits Unit
5901 Market Street Tele: 215-386-3838, Ext. 11121
Philadelphia, PA 19139 **Dedicated Fax: 215-438-5484**

From:	Employee's Name	
	Home Phone:	
	Home Address	
	Email Address:	

Employee Name:		EE Member ID #:	
Patient Name:		Patient Member ID #:	
Date(s) of Inpatient Hospital/SNF Stay:		Total Inpatient Hospital/SNF cost payable by Member	
Name of Hospital/SNF:		Hospital/SNF - Address for payments	
Patient's Account #			

ATTACHMENTS

- o Explanation of Benefits from Health Plan
- o Hospital or SNF Invoice indicating what you owe
- o Receipt of payment if member paid the Hospital or SNF and is seeking reimbursement from Horizon House.

Employee Signature: _____ Date: ___/ ___/ ____