



WEA Administrators
2525 Embassy Drive, Suite #15
Cooper City, Florida 33026 USA
Phone 1 (954) 889-2100
Fax 1 (954) 241-2002
Email info@wwexpa.com

A. INSTRUCTIONS

1. Submits all correspondence to **WEA Administrators** all the above address.
2. Claims inquiries or verification of coverage may also be telephoned or faxed to the above numbers.
3. It is important that you show your WEA identification card when seeking the services of a provider.
4. To assist the provider in submitting your claim, our address and the Customer Service telephone numbers are printed on the reverse side of your card.

B. PLEASE SUBMIT

GENERAL CLAIM FORM INFORMATION

1. Separate receipts and itemized bills if more than one (1) claimant.
2. Separate completed claim form for each claimant with appropriate receipts and itemized bills attached.
3. Claim form **must** be completed with:
 - claimant's name and date of birth
 - policy number
 - correct diagnosis (**Note:** may be in layman's terms such as stomach ache, sore throat, broken leg, etc.)
4. Maternity Claims must include a fully completed Maternity Questionnaire (available on-line).
5. Please keep copies of all your claims for your personal records.
6. After your claims have been submitted and processed you will receive an Explanation of Benefits. The EOB will describe your claims reimbursement including allowable charges, amount applied to your deductible, percentage of reimbursement and refused charges.
7. Always carry your insurance card with you. This provides you and your provider with your identification number, which is needed for your claim form.

INVOICES / BILLS

Originals Only-- No Photocopies or Faxed Copies

1. Doctor's invoices/bills **must** include:
 - medical providers name, address and signature
 - claimant's name
 - doctor's specialty (obstetrics, pediatrics, neurology, etc.)
 - detailed description of service rendered (office visits, surgery, etc.)
 - dates of service
 - diagnosis
 - charge for service
2. Pharmacy receipts **must** include:
 - claimant's name
 - name of prescribing physician
 - name of prescription
 - date of prescription
 - charge for medication
 - pharmacy name, telephone number and address
3. Hospital bills/invoices **must** include:
 - claimant's name
 - referring/trating Dr. Name
 - dates of admission and discharge
 - diagnosis/reason for hospitalization
 - itemized hospital bill (**Note:** Tax and patient convenience items such as telephone and television are non-covered items.)