HEALTH ADVANTAGE BILLING ADJUSTMENT FORM for Month_____Acct Rep*_____

(If Applicable)

Group Name_____**Group #**_____

Address_____

Telephone_____**Group Administrator**_____

Health Advantage
Attn: Membership Accounting
P.O. Box 8069
Little Rock, AR 72203-8069

☐ **Indicate if Change in Group Information**

Division Number	Action Code	Subscriber SSN	Subscriber Name	Effect date M/D/Y	TERM date M/D/Y	Contract Type	Explanation	DEDUCT from bill	ADD to bill	Net Change

A = Add Member (Application)
D = Cancel Coverage
C = Change in Contract type (Attach Application /change form)

Reason for Cancellation:
Reduction in hours/Terminated employment
Subscriber Request (attach subscriber letter)
Deceased

***Group Account Representative is the person that handles the membership and premium for the group at Health Advantage**

>>>>>>>>>>>Please attach this Adjustment Form to the Health Advantage bill for the month that is being paid<<<<<<<<<<<