Geisinger Health Plan

RECONCILIATION WORKSHEET FOR PAYMENT OF PREMIUM

Please complete this worksheet to indicate any difference between the amount remitted and the amount billed. Please email this worksheet to ghp_acct_rec@geisinger.edu or fax to 570-555-5555. Please do not include this worksheet with your check. Thank you.

			Current Premium Adjustments		Retroactive Premium Adjustments	
Subscriber Name	**Subscriber ID #**	**Effective Date (Month/Year)**	**Additions (1)**	**Terminations (2)**	**Additions (1)**	**Terminations (2)**
		TOTALS:	$	$	$	$

Current Premium This Coverage Period: _____

Additions (1): _____

Terminations (2): _____

Net of (3) and (4) Retro Adjustments: _____

Total Amount Paid: _____

PLEASE NOTE: All adjustments are to be supported with the required application or change form. If form(s) have not yet been submitted, mail immediately to: Geisinger Health Plan, Attn: Enrollment 25-80, 100 N. Academy Ave., Danville PA 17822-2580

Retroactive changes are limited to the time-frame set forth in the Group Service Agreement.

_____

Signature and phone number of person completing this form