

Mail to:  
 CBA Blue  
 P.O. Box 2365  
 South Burlington, VT 05407-2365  
 Fax to: (802) 864-8115



## Medical Claim Form

Employee Information		
1. Last Name:	2. First Name:	3. Mid:
4. Street Address:		4a. Apt./Unit #
5. Birth Date: / / <small>month day year</small>	6. Marital Status:	
7. City:	8. State:	9. Zip:
10. Home Phone: ( )	11. Alternate Phone: ( )	
12. Email Address:		
13. Employer Name:		
14. Group Number (from your ID Card):		
15. Member Identification Number (from your ID Card):		
Patient Information		
16. Last Name:	17. First Name:	18. Mid:
19. Street Address:		19a. Apt./Unit #
20. City:	21. State:	22. Zip:
23. Birth Date: / / <small>month day year</small>	24. Patient's Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	
25. Relationship to Participant: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other _____		
26. Home Phone: ( )	27. Alternate Phone: ( )	
28. In addition to coverage under this program, is the patient covered under any other insurance providing health care benefits or services?		
<input type="checkbox"/> No <input type="checkbox"/> Yes If "Yes", please complete below:		
a. Name of Policy Holder _____		b. Relationship to Patient _____
c. Name of Insurer _____		
d. Policy or Certificate Number _____		e. Effective Date of Coverage: / / <small>month day year</small>
Claim Information		
29. Is this claim the result of an accidental injury? <input type="checkbox"/> No <input type="checkbox"/> Yes If "Yes", please complete below:		
29a. Injury Date: / / <small>month day year</small>	29b. Where accident occurred and details:	
30. Was the injury in any way work related? <input type="checkbox"/> No <input type="checkbox"/> Yes		
31. Date of Service(s):		
32. Provider(s) of Service:		
33. Reimbursement should be provided to: <input type="checkbox"/> Member <input type="checkbox"/> Provider of Service		

I certify that the above is complete and correct and that I am claiming benefits only for charges incurred by the patient above. Authorization is hereby given to any hospital, physician, or other provider which participated in any way in my care and treatment to release to CBA Blue any medical information which they in their judgment deem necessary to the adjudication of this claim.

Participant Signature \_\_\_\_\_ Date \_\_\_\_\_

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## Medical Claim Form Instructions

### Employee Information:

1. Last Name
2. First Name
3. Middle Initial
4. Street Address (Mailing Address) 4a. Apartment or Unit Number
5. Birth Date
6. Marital Status (Single, Married, Divorced)
7. City
8. State
9. Zip
10. Home Phone
11. Alternate Phone (cellular, office, or other)
12. Email Address
13. Employer Name
14. Group Number (five digit number from your ID card)
15. Member Identification Number (include the three leading alpha character and nine digit suffix)

### Patient Information (if you are submitting claims for more than one patient, use multiple forms):

16. Patient's Last Name
17. Patient's First Name
18. Patient's Middle Initial
19. Patient's Street Address (if different from Employee) 19a. Apartment or Unit Number
20. Patient's City (if different from Employee)
21. Patient's Zip (if different from Employee)
22. Patient's Zip (if different from Employee)
23. Patient's Date of Birth
24. Patient's Sex
25. Patient's Relationship to Employee (if "other" – please describe)
26. Patient's Home Phone
27. Patients Alternate Phone (cellular, office, or other)
28. Provide Other Insurance Information If

### Claim Information:

29. Indicate if claim was the result of an accidental injury, check yes or no 29a. & 29b. Date/Details Injury
30. If Injury, indicate if work related
31. Date(s) Of Service of Claim(s) being submitted for reimbursement
32. Provider(s) of Service for claims being submitted
33. Indicate where reimbursement should be sent

**Sign form and remit to CBA Blue to the address or fax number listed at the top of this form. Please include an itemized bill(s) from the provider(s) of service. Claims filed for prescription reimbursement should include the pharmacy receipt (not cash register receipt. Attach prescriptions to a separate piece of paper.**