CDPHP® Member Claim Form

Member: Use this form to request reimbursement of out-of-pocket expenditures for Covered Services. Reimbursement will be made to the Subscriber and sent to the address on file.

1	Member Name			Member ID Number
2	Address—Number and Street City State ZIP			Date of Birth
3	Type of Service(s) Received ☐ Out-of-area urgent care ☐ Vision ☐ Out-of-area hospitalization ☐ Other _____ ☐ Dental			
4	Describe Accident or Illness			Diagnosis Code (if known)
5	Date of Service	Procedure Code(s)	Procedure Description(s)	Charge(s)
6	Servicing Provider/Facility Name			
7	Provider Address			
8	Provider Telephone Number			

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and shall be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for such violation.

Signature_____ Date Signed_____

Please enclose any related, itemized bills indicating patient's name, date of service, the type of service rendered, the nature of the condition being treated. If any information is missing, please write it on the bill yourself and sign your name. Mail completed form and documentation to:

CDPHP
PO Box 66602
Albany, NY 12206-6602

Member Claim Form Filing Instructions

Your claim is important to us. To assist CDPHP in reimbursing your out-of-pocket expenditures properly, please complete this medical claim form.

Review the guidelines listed below to ensure all necessary information is included when filing your claim.

☐ **Date of service –** Date service(s) occurred or date item was purchased.

☐ **Provider's name and address –** Who delivered the service, or if a purchase, where item was purchased.

☐ **Description of service –** Description of the service or product you received.

☐ **Proof of Payment –** The amount you paid for the service or product.

- Circle the dollar amount being claimed on each receipt. Do not use a highlighter.
- If you are covered by another form of insurance for the services provided, you should submit those charges to the other insurer first. Send a copy of any Explanation of Benefits (EOBs) you receive, along with this claim form.
- If you have dental insurance, please include a copy of your EOB with your proof of payment.

Keep a copy of the claim form and supporting documents for your records.

In the event you are asked to resubmit a claim due to lacking information, please enclose our letter that requested the information when you send the additional documentation.

All information should be sent to:

CDPHP
PO Box 66602
Albany, NY 12206-6602