

MAIL TO: CEBT/CNIC  
P.O. Box 76149  
Colorado Springs  
CO 80970

# MEDICAL CLAIM FORM CEBT

Group: CEBT

Employee's Statement (see instructions on other side)

## EMPLOYEE INFORMATION:

NAME (Last)	(First)	(Middle)	SOCIAL SECURITY NUMBER / /
ADDRESS (Street)	(City)	(Zip Code)	OCCUPATION:
DATE OF BIRTH (month, day, year) / /	SEX <input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> MARRIED <input type="checkbox"/> SINGLE	<input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOW(ER)

## DEPENDENT INFORMATION: COMPLETE ONLY IF PATIENT IS A DEPENDENT

DEPENDENT'S NAME	DATE OF BIRTH (mo. day yr.) / /	RELATIONSHIP <input type="checkbox"/> CHILD <input type="checkbox"/> SPOUSE <input type="checkbox"/> OTHER	IS CHILD-PATIENT EMPLOYED? <input type="checkbox"/> YES <input type="checkbox"/> PART-TIME <input type="checkbox"/> NO <input type="checkbox"/> FULL-TIME
SEX <input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> SINGLE <input type="checkbox"/> WIDOW(ER)	<input type="checkbox"/> LEGALLY SEPARATED	IS CHILD-PATIENT OVER AGE 19 FULL TIME STUDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO IF "YES", GIVE NAME & ADDRESS OF SCHOOL.

## OTHER COVERAGE INFORMATION: COMPLETE IN ALL CASES

NAME OF SPOUSE	IS SPOUSE EMPLOYED? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF "YES", BY WHOM: (GIVE EMPLOYER NAME & ADDRESS)
IS SPOUSE INSURED UNDER EMPLOYER'S GROUP HEALTH PLAN? <input type="checkbox"/> YES If "YES", give name and address of insurance company. <input type="checkbox"/> NO	POLICY NUMBER	SPOUSE'S SOCIAL SECURITY NUMBER / /
DOES SPOUSE CARRY DEPENDENT COVERAGE? <input type="checkbox"/> YES <input type="checkbox"/> NO		
IS PATIENT COVERED BY ANY OTHER PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO—COVERAGE OF MEDICAL CARE EXPENSES PROVIDED BY A SCHOOL, FEDERAL, STATE, PROVINCIAL OR GOVERNMENT AGENCY INCLUDING UNION OR ASSOCIATIONS? <input type="checkbox"/> YES <input type="checkbox"/> NO—NO FAULT AUTOMOBILE INSURANCE AS A RESULT OF INJURIES SUSTAINED IN AN AUTOMOBILE ACCIDENT? IF ANY OF THE ABOVE ARE "YES", GIVE NAME OF POLICY AND POLICY NUMBER. <input type="checkbox"/> YES <input type="checkbox"/> NO—MEDICARE: TYPE A (HOSPITAL) <input type="checkbox"/> YES <input type="checkbox"/> NO—MEDICARE: TYPE B (PHYSICIAN AND OTHER SERVICES)		

## NATURE OF ACCIDENT AND/OR ILLNESS: COMPLETE IN ALL CASES

DESCRIBE CONDITION OR ILLNESS:

IF ILLNESS, HAS PATIENT EVER HAD SAME OR SIMILAR ILLNESS?  YES  NO  
IF "YES", GIVE DATE LAST TREATED.      mo. / day / yr.

DID CONDITION RESULT FROM ACCIDENTAL INJURY? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF "YES", GIVE DATE: (mo. day yr.) / /	TIME <input type="checkbox"/> A.M. <input type="checkbox"/> P.M.
PLACE: (HOME, WORK, HIGHWAY, ETC.)	DESCRIBE HOW ACCIDENT HAPPENED:	

I agree to reimburse Colorado Employees Benefit Trust if this claim for sickness/injury is compensable under Medicare, Workmen's Compensation Act, or similar law or if such claim is settled or compromised, or if benefits excluded by the non-duplication provisions of the contract are paid.  
I hereby authorize any physician, hospital, insurance company, service plan, employer, organization or association to release to CEBT any information regarding medical history, treatment, disability, or benefits paid or payable for this claim. A copy of this authorization shall be as valid as the original.  
**All of the above statements are true and complete to the best of my knowledge.**

EMPLOYEE'S SIGNATURE **X** \_\_\_\_\_ DATE SIGNED \_\_\_\_\_  
(signature necessary on all claims)      month      day      yr.

SIGNATURE OF PATIENT **X** \_\_\_\_\_ DATE SIGNED \_\_\_\_\_  
(required only if patient is spouse)      month      day      yr.

## AUTHORIZATION FOR DIRECT PAYMENT: COMPLETE ONLY IF YOU WISH PAYMENT TO BE MADE DIRECTLY TO A HOSPITAL, PHYSICIAN, ETC. INSTEAD OF YOU.

I authorize payment of medical benefits for services rendered by (specify) \_\_\_\_\_  
Date \_\_\_\_\_ Employee's Signature **X** \_\_\_\_\_

(over)

# MEDICAL CLAIM INSTRUCTIONS

Check to see that all required information has been completed and that the form has been **signed**. Failure to completely fill out the form may **delay** payment of your claim.

## WHEN TO FILE A CLAIM:

As eligible expenses are incurred. However, unless major expenses are involved, we suggest you accumulate your bills and file them periodically during the year.

## FILING PROCEDURE:

Claim forms are available from the Administrative Offices.

A claim form should be submitted for **each member** of the family for whom claims are made. A claim form should be filled out **each time** bills are submitted.

Completed claim forms, together with **itemized bills**, are to be sent to The Urman Company (address below).

If claim forms are to be sent by the physician and/or hospital, a **separate** claim form, properly completed, should be given to **each** provider of service.

## TIMELY CLAIMS SUBMISSION:

All claims are required to be submitted prior to July 1 of the next calendar year. If claims are not submitted within these guidelines, payment will not be assured.

## ITEMIZED BILLS:

Bills for services and treatment must include the information indicated below. Failure to submit complete bills will **delay** processing of your claim. Lists of expenses or statements of "Balance Due" are not acceptable.

**Physician** — Bills must show patient's name, date(s) of treatment, nature of treatment, **diagnosis** and charges.

**Prescription Drugs** — Receipts must show patient's name, prescription number, date and charges. When submitting each prescription drug charge for the first time, please include a **diagnosis** from your physician.

**X-ray, lab, medical equipment, registered nurses, etc.** — Bills must show patient's name, nature of service, date(s) of service, place of service, charges, and **diagnosis** from referring physician.

## MAIL CLAIMS TO

**CNIC**  
P.O. Box 76149  
Colorado Springs, CO 80970

**NOTE: PROVIDERS—FOR INFORMATION, PLEASE CALL (303) 773-1373**

## PRE-CERTIFICATION REQUIREMENT

Your group medical plan does require a pre-admission certification for all hospital admissions.

If an employee or dependent is being admitted to a hospital, a pre-admission certification is necessary to obtain your eligible benefits after the deductible. Employees and dependents must have their doctor contact FHP Employee Benefits at **1-800-255-1189** to obtain a pre-admission certification. There will be an additional \$250 deductible if no pre-admission certification is obtained.

Emergency admissions must be certified by CNIC within 48 hours of the emergency admission. These certifications are required on all hospital admissions in order for eligible benefits to be paid after the deductible. There will be an additional \$250 deductible if no pre-admission certification is obtained.

Please have your doctor call CNIC if you plan to be admitted to a hospital. This will enable you to receive the standard benefits from your plan.

Please feel free to contact The Urman Company or your service representative if you should have any questions.

07/2007