

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



Medical Claim Form

Please note: Each claim must be accompanied by an itemized bill from the facility or provider showing both procedure and diagnosis codes. In addition to an itemized bill, the applicable claim form must also be submitted with each submission. This includes online portal submissions.

Employee Information		
Last Name:	First Name:	Mid:
Street Address:		Apt./Unit #
Birth Date: / / <small>month day year</small>	Marital Status:	
City:	State:	Zip:
Home Phone: ()	Alternate Phone: ()	
Email Address:		
Employer Name:		
Group Number (from your ID Card):		
Member Identification Number (from your ID Card):		
Patient Information		
Last Name:	First Name:	Mid:
Street Address:		Apt./Unit #
City:	State:	Zip:
Birth Date: / / <small>month day year</small>	Patient's Sex: Male <input type="checkbox"/> Female <input type="checkbox"/>	
Relationship to Participant: Self Spouse Child Other		
City:	State:	Zip:
Home Phone: ()		Alternate Phone: ()
In addition to coverage under this program, is the patient covered under any other insurance providing health care benefits or services?		
No <input type="checkbox"/> Yes <input type="checkbox"/> 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		
Is this claim the result of an accidental injury? <input type="checkbox"/> No <input type="checkbox"/> Yes If "Yes", please complete below:		
Injury Date: / / <small>month day year</small>	Where accident occurred and details:	
Was the injury in any way work related? <input type="checkbox"/> No <input type="checkbox"/> Yes		
Reimbursement should be made to: <input type="checkbox"/> Member <input type="checkbox"/> Provider		

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 _____