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.

Employee Information

Last Name: First Name: Mid:

Street Address: Apt./Unit #

Birth Date: / / (month / day / year) 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: / / (month / day / year) Patient's Sex: 0 Male 0 Female

Relationship to Participant: 0 Self 0 Spouse 0 Child 0 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?

0 No 0 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: / / (month / day / year)

Claim Information

Is this claim the result of an accidental injury? 0 No 0 Yes If "Yes", please complete below:

Injury Date: / / (month / day / year) Where accident occurred and details:

Was the injury in any way work related? 0 No 0 Yes

Reimbursement should be made to: 0 Member 0 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** _____

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