# HEALTH CARE BENEFITS CLAIM FORM

COMMUNITY FIRST HEALTH PLANS

## A. Subscriber / Employee Information

| Last Name: | First Name: | MI: | Date of Birth |
|---|---|---|---|
| Home Address: | | New Address: ☐ Yes ☐ No | |
| City: | State: | Zip Code: | |
| Phone #: | CFHP ID #: | Group # | |

## B. Patient Information

| Last Name: | First Name: | MI: | Date of Birth |
|---|---|---|---|
| Home Address: | | | |
| City: | State: | Zip Code: | |
| Sex: ☐ M ☐ F | Relationship to Subscriber: | | |

## C. Accident Information

| Is claim related to an accident? ☐ Yes ☐ No | Date of Accident: | Type of Accident ☐ Work Injury ☐ Motor Vehicle ☐ Other: |
|---|---|---|
| How did the accident occur? | | |

## D. Other Insurance

| Is the patient covered by another insurance plan? ☐ Yes ☐ No *If Yes, please complete the following:* | |
|---|---|
| Name of Subscriber on other insurance: | Date of Birth |
| SSN: | Name of Other Insurance Carrier: |
| Policy Number: | Employer Name: |

**Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.**

Subscriber Signature:_____ Date: _____

## E. Assignment of Benefits

Please sign below *only if you want Community First Health Plans to pay benefits directly to the provider* of medical services.

Subscriber Signature:_____ Date: _____

## Guidelines for submitting claims to Community First Health Plans

**Claims must be submitted within 60 days from the date of service.**

1. Clip your original bill with diagnosis code, procedure code, date of service and cost to the completed form.
2. Mail the documents to: Community First Health Plans Inc., 12238 Silicon Dr. #100, San Antonio, TX 78249
3. Use a separate form for each family member.
4. ASSIGNMENT: If you wish benefits to be paid directly to the physician or provider of service, sign the Assignment of Benefits box. NOTE: Benefits for a hospital confinement will be paid directly to the hospital.