COMMUNITY FIRST HEALTH PLANS

HEALTH CARE BENEFITS CLAIM FORM

Your reason for submitting this claim: (check box for all that apply)

☐ The provider or supplier refused to file a claim for Medicare Covered Services.
☐ The provider or supplier is unable to file a claim for the Medicare Covered Services.
☐ The provider or supplier is not enrolled with Medicare.

A. Subscriber / Employee Information

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

B. Patient Information

Last Name:	First Name:	MI:	Date of Birth
Home Address:		New Address: Yes ☐ No ☐	
City:	State:	Zip Code:	
Sex: Male ☐ Female ☐	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?		

Toll-Free: 1-833-434-2347 | TTY: 711 | 12238 Silicon Dr. Ste 100, San Antonio, TX 78249 | CommunityFirstMedicare.com

D. Provider Information

(This section is mandatory for claim processing. Please obtain this information from your provider or request that they complete it on your behalf.)

Name:	Provider Tax Identification Number:	NPI Number:	
Group/Facility Name:	Provider Address:	Address where services were rendered:	
City:	State:	Zip Code:	Phone Number:

E. 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:	
Effective Date of Other Insurance:	Cancellation Date of Other Insurance:	Did you attach an EOB from Medicare or your other insurance? Yes ☐ No ☐

I certify, under penalty of perjury, that I have reviewed all information provided on this form and any accompanying documents, and that it is true and accurate to the best of my knowledge. I understand that anyone who knowingly provides false or misleading information required by this form may, upon conviction, be subject to fines and imprisonment under Federal law.

Subscriber Signature:_____ Date: _____

F. 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.

IMPORTANT: The following information must appear on the bill to ensure your claim is processed. Missing or incomplete details may result in delays or denial of payment. Please verify that all information is clear and legible.

1. Attach the original itemized bill. It must include: patient name, procedure code, diagnosis code, date of service, charges for each service, and provider information.
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.