MAIL TO: CEBT/CNIC
P.O. Box 3559
Englewood, CO 80155-3559

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 ☐ M ☐ F | ☐ MARRIED ☐ SINGLE ☐ DIVORCED ☐ WIDOW(ER)

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

DEPENDENT'S NAME | DATE OF BIRTH (mo. day yr.) ___/___/___ | RELATIONSHIP ☐ CHILD ☐ SPOUSE ☐ OTHER | IS CHILD-PATIENT EMPLOYED? ☐ YES ☐ NO ☐ PART-TIME ☐ FULL-TIME

SEX ☐ M ☐ F | ☐ MARRIED ☐ SINGLE ☐ DIVORCED ☐ WIDOW(ER) ☐ LEGALLY SEPARATED | IS CHILD-PATIENT OVER AGE 19 FULL TIME STUDENT? ☐ YES ☐ NO IF "YES", GIVE NAME & ADDRESS OF SCHOOL.

OTHER COVERAGE INFORMATION: *COMPLETE IN **ALL** CASES*

NAME OF SPOUSE | IS SPOUSE EMPLOYED? ☐ YES ☐ NO | IF "YES", BY WHOM: (GIVE EMPLOYER NAME & ADDRESS)

IS SPOUSE INSURED UNDER EMPLOYER'S GROUP HEALTH PLAN? ☐ YES If "YES", give name and address of insurance company. ☐ NO | POLICY NUMBER | SPOUSE'S SOCIAL SECURITY NUMBER ___/___/___

DOES SPOUSE CARRY DEPENDENT COVERAGE? ☐ YES ☐ NO

IS PATIENT COVERED BY ANY OTHER PLAN?
☐ YES ☐ NO—COVERAGE OF MEDICAL CARE EXPENSES PROVIDED BY A SCHOOL, FEDERAL, STATE, PROVINCIAL OR GOVERNMENT AGENCY INCLUDING UNION OR ASSOCIATIONS?
☐ YES ☐ 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.

☐ YES ☐ NO—MEDICARE: TYPE A (HOSPITAL) ☐ YES ☐ 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? ☐ YES ☐ NO | IF "YES", GIVE DATE: (mo. day yr.) ___/___/___ | TIME ☐ A.M. ☐ 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 CNIC (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 within 12 months of the date of the service. 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 3559
Englewood, CO 80155-3559

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 CNIC at **1-800-255-1189** to obtain a pre-admission certification.

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.

06/2011