Community First Group Hospital Service Corporation

PPO HEALTH CARE BENEFITS CLAIM FORM

To Be Completed by Employee

INSTRUCTIONS: Claims must be submitted within 180 days from the date of service

1. Complete ALL information requested below
2. Use separate form for each family member and for each accident or illness.
3. Attach ORIGINAL itemized bills. Receipts and cancelled checks ARE NOT acceptable.
4. ASSIGNMENT: If you wish benefits to be paid directly to the physician or provider of services, sign in the Direct Payment block below. NOTE: Benefits for a hospital confinement will be paid directly to the hospital.

Return Address: Community First Health Plans
12238 Silicon Drive, Suite 100
San Antonio Texas 78249

☐ Check here if covered through COBRA continuation provision

1. Employee's Name: (Last Name, First Name, M.I.)	2. Group Name:	3. Group # (First 6 digits):
4. Employee's Home Address: Phone Number:	5. Social Security # (ID Number):	6. Employee's Date of Birth:
	7. Employee's Employment Status: ☐Active ☐Retired ☐Disabled	
8. Patient's Name: (Last Name, First Name, M.I.)	9. Patient's Date of Birth:	10. Patient's Gender: ☐ Male ☐ Female
11. Patient's Relationship to Employee: ☐ SELF ☐ SPOUSE ☐ CHILD Is Child: ☐ Under 25 ☐ Full-Time Student ☐ Single ☐ Handicapped ☐ Part-Time Student ☐ Married	12. Patient's Employment Status: ☐Active ☐Retired ☐Disabled	
	Full-Time Student-Expected Date of Graduation:	Full-Time Student-Name of School:
13. Is Patient Covered by Other Group Health Plan: ☐Yes ☐No	14. Spouse's Social Security Number:	
15. Plan/Policy Number: / 16. Name and Address of Other Health Carrier:	17. Is Your Spouse Employed? ☐ Yes ☐ No	
	18. Name, Address, and Phone Number of Spouse's Employer:	
19. Did the accident occur while on the job? ☐ Yes ☐ No		
20. Did the accident involve a motor vehicle? ☐ Yes ☐ No	21. Date of Accident:	22. Was a police report made? ☐ Yes ☐ No
23. Name, Address, and Telephone of Your Vehicle Insurance Carrier:	24. Name and Address of Other Vehicle Owner Involved:	
25. Did you file a claim with your Insurance Carrier? ☐ Yes ☐ No (If YES, attach a copy of claim submitted)	26. Name, Address, and Telephone of Other Vehicle Owner's Insurance Carrier:	

RELEASE OF INFORMATION	**IF PAYMENT IS TO BE SENT DIRECTLY TO**
I authorize the release of any medical information necessary to process this claim. I understand that, as permitted by law, to the extent of benefits paid under this claim, the Plan acquires all rights of recovery I may have against other parties considered responsible for these expenses.	I hereby authorize payment directly to the provider of services and I understand that I am financially responsible for the hospital, medical, or physician charges not covered by this authorization.
27. Patient or Authorized Person's Signature Date	28. Employee's Signature Date

ART 3.97.2 NOTICE OF PENALTY FOR FALSE OR FRAUDULENT CLAIMS: ***Any person who knowingly presents a false or fraudulent claim for payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.***