

Supplemental Claim Form

(additional instructions on reverse side)

SUBSCRIBER INFORMATION

Member ID Number: _____ Status: faculty/staff/associate student

Name: _____
last first MI

Address (#, Street, Apt #): _____ City _____ State _____ Zip _____

Telephone number: _____

PATIENT INFORMATION

Relationship of patient to subscriber

D.O.B. _____ Male Female self spouse dependent

Last name: _____ First name: _____

TYPE OF SERVICE/CLAIM

- Chiropractic Durable medical equipment
 Home health services Other

Brief description of illness or injury: _____

Is injury related to: Automobile accident yes no
Workers' Compensation claim yes no
Other liability yes no

Date illness/injury began:

Policy membership #

Is patient covered by another insurance plan? yes no

Employee member/subscriber name & address _____

Employer/school name & address _____

Insurance plan name & address _____

PAYMENT AUTHORIZATION

- I authorize payment of attached expenses to be paid directly to the physician or provider.
 I direct Yale Health to reimburse the subscriber.

Signature: _____ Date: _____

AUTHORIZATION TO RELEASE INFORMATION - I hereby authorize any provider, insurance company, employer or organization to release all information regarding the medical, dental, or drug history, treatment and benefits payable concerning this claim to **Yale Health** for the purposes of validating and determining benefits payable in connection with this claim.

Signature: _____ Date: _____

**INSTRUCTIONS FOR FILING
YALE HEALTH SUPPLEMENTAL CLAIMS**

- **A separate claim form** is needed for **each** family member.

- **Itemized bills must include:**
 - Patient name
 - Type of service
 - Date of service
 - Diagnosis
 - Charge for service

- **Send completed claim form and bills to:**

Yale Health
Business Office
55 Lock Street, 3rd Floor
P.O. Box 208217
New Haven, CT 06520-8217

**CLAIMS DEPARTMENT
203-432-0250**