Yale University Retirees Major Medical Claim Form

(Additional instructions on reverse side)

RETIREE INFORMATION

Social Security Number _____ Date of Birth_____ ☐ Male ☐ Female

Last Name: _____ First Name: _____

Address (#, Street, Apt #)_____ City_____ State_____ Zip Code_____

Telephone Number: _____

PATIENT INFORMATION

RELATIONSHIP TO INSURED

Social Security Number_____ ☐ Self ☐ Spouse ☐ Dependent

Last Name_____ First Name: _____

D.O.B. _____ ☐ Male ☐ Female

Date and Description of accident or injury (if applicable)_____

Dates (within the past 6 months) of any recent inpatient hospitalizations or one day surgery procedures _____. Please provide a copy of the Medicare Summary Notice or a copy of the billing information from the hospital or medical center where these services were provided, indicating the date services were provided.

Is patient covered by another insurance plan? ☐ Yes ☐ No If yes, please complete this section.

SUBSCRIBER AND POLICY INFORMATION

Subscriber's Name_____ Policy #_____

Insurance Co. Name_____

Address_____ Telephone Number_____

PAYMENT AUTHORIZATION

☐ I authorize payment of attached expenses be paid directly to the provider indicated.
☐ I authorize payment of attached expenses be paid directly to the patient.

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 the Yale University Retiree Claims processing center for the purposes of validating and determining benefits payable in connection with this claim.

Signature:_____ Date:_____

ATTACH BILLS AND RECEIPTS TO THIS FORM

MAIL TO: Yale University Retirees Processing Center
P.O. Box 208357
New Haven, CT 06520-8357

Telephone Numbers:
203-432-7513
Toll free: 1-877-947-2273

1 **Please allow 3 weeks from the date of mailing before calling concerning pending claims.**

INSTRUCTIONS FOR FILING A CLAIM

RETIREE INFORMATION:

The Yale Employee should complete this section. Please make sure Social Security Number is correct.

PATIENT INFORMATION:

This section is to be completed by the patient. Please use a separate claim form for each retiree.

PAYMENT AUTHORIZATION:

This section is to be completed and signed indicating if the payment is to be made to the provider or the patient.

ATTACHMENTS REQUIRED

Bills must include:

Retiree name
Patient name
CPT code
Diagnosis
Charge for service
Date of service
Physician or provider name, address and tax ID number

Prescription Receipts must include:

Patient name
Physician name
Prescription name
Prescription number
Prescription date
Prescription charge

NOTE: No payments will be made if Medicare Assignment has been accepted by the physician or the provider.

Retiree Medicare Patients who are submitting claims for non Medicare covered services must include a copy of the Medicare Summary Notice. No claims will be processed without the Medicare Summary Notice.

Please make copies of all bills submitted - bills are not returned to you.

Save all Medicare Summary Notices statements you receive.

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