Yale HEALTH

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
  - Procedure code

- **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