



Yale University Retirees Major Medical Claim Form

(Additional instructions on reverse side)

RETIREE INFORMATION

Social Security Number _____ Date of Birth _____

Last Name _____ First Name _____ Preferred Name _____

Address _____ City _____ State _____ Zip Code _____

Phone Number _____

PATIENT INFORMATION

RELATIONSHIP TO INSURED

Social Security Number _____ Self Spouse Dependent

Last Name _____ First Name _____

D.O.B. _____ Preferred Name _____

If patient is covered by another insurance plan, please complete this section.

SUBSCRIBER AND POLICY INFORMATION

Subscriber's Name _____ Policy # _____

Insurance Co. Name _____

Address _____

Phone 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 validating and determining benefits payable in connection with this claim.

Signature _____ Date _____

MAIL THIS FORM WITH ATTACHED CLAIMS AND RECEIPTS TO:

Yale Health Business Office
 Yale University Retirees Processing Center – Claims Dept.
 P.O. Box 208217
 New Haven, CT 06520-8217
 Phone (203)-432-0250

**Please allow 30 days for processing of 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 Diagnosis
Patient name Charge for service
CPT code 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 Notice statements you receive.

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