CCHP Health Plan

CLAIM FOR EMERGENCY MEDICAL SERVICES

In order for your claim to be considered for payment:

- Both sides of this form must be completed in full
- All itemized bills and proof of payment for this emergency must be attached
- This form must be signed, see below
- In most cases, payment will be made to provider(s) unless proof of payment is furnished by the member or provider(s)

Patient Name:	Sex: Birthdate:	
Patient Address:	Telephone:	
Subscriber Name:	Relation to Patient:	
Subscriber Address:	Telephone:	
Place of Illness / Injury:	Incident Date:	Time:
Place of Emergency Care:	Treatment Date:	Time:
Is the Patient covered by other medical insurance?	Yes ☐	No ☐
If yes, Insurance Company Name:		
Name of Policy Holder / Subscriber:	Subscriber ID Number:	

Member's description of how the emergency occurred:

Was an ambulance used?	Yes ☐	No ☐
Who called the ambulance?		

If hospitalized:

Name of Hospital:	
Admit Date:	Discharge Date:
When did you notify CCHP?	
With whom did you speak?	
Name of your CCHP Primary Care Physician:	

Was the injury or illness work-related?	Yes ☐	No ☐
If yes, please attach an explanation of payment or denial from the workers' compensation carrier.		
Was this injury the result of a motor vehicle accident?	Yes ☐	No ☐
If yes, please send a copy of the auto policy face sheet for the vehicle in which the patient was riding.		

If you have retained an attorney, please give the attorney's contact information.

Attorney's Name:
Attorney's Address:
Attorney's Number:

I authorize_____(name of providers) to release any and all information, including medical and/or hospital records pertaining to the health care services provided to me on/between the dates listed on this Claim for Emergency Medical Services. I understand that this information is necessary to allow CCHP to process my claims for payment of these services.

Authorizing Signature: (*Parent's signature, if the patient is a minor)* **Date**