CDPHP® Member Claim Form

Member: Use this form to request reimbursement of out-of-pocket expenditures for Covered Services.

1	Member Name			Member ID Number
2	Address—Number and Street City State ZIP			Date of Birth
3	Type of Service(s) Received ☐ Out-of-area urgent care ☐ Out-of-area hospitalization ☐ Dental ☐ Vision ☐ Other _____			
4	Describe Accident or Illness			Diagnosis Code (if known)
5	Date of Service	Procedure Code(s)	Procedure Description(s)	Charge(s)
6	Servicing Provider/Facility Name			
7	Provider Address			
8	Provider Telephone Number			

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and shall be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for such violation.

Signature_____ Date Signed_____

Please enclose any related, itemized bills indicating patient's name, date of service, the type of service rendered, the nature of the condition being treated. If any information is missing, please write it on the bill yourself and sign your name. Mail completed form and documentation to:

CDPHP
PO Box 66602
Albany, NY 12206-6602

Capital District Physicians' Health Plan Inc. ● CDPHP Universal Benefits, Inc. ● Capital District Physicians' Healthcare Network, Inc.

11-0654-0711