FILE MEDICAL CLAIMS TO:

CMR
PO Box 7121
London, KY 40742-7121
Emdeon/Electronic Payor ID: 25133

CLAIM FORM

1. EMPLOYER/GROUP NAME/GROUP NUMBER **EGYPTIAN AREA SCHOOLS EMPLOYEE BENEFIT TRUST**		1a. EMPLOYEE SOCIAL SECURITY NUMBER
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE SEX MM DD YY M ☐ F ☐	4. EMPLOYEE NAME (Last Name, First Name, Middle Initial)
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO EMPLOYEE Self ☐ Spouse ☐ Child ☐ Other ☐	7. EMPLOYEE ADDRESS (No., Street)
CITY / STATE	8. NATURE OF ILLNESS OR INJURY. IF INJURY, HOW DID ACCIDENT OCCUR?	CITY / STATE
ZIP CODE / TELEPHONE (Include Area Code) ( )		ZIP CODE / TELEPHONE (Include Area Code) ( )
9. OTHER COVERAGE, INCLUDING MEDICARE ☐ YES ☐ NO EFFECTIVE DATE _____		

11. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I hereby authorize the release of any medical or other information necessary to process this claim.

SIGNED_____ DATE_____

12. ASSIGNMENT: I hereby authorize payment directly to the hospital, physician, dentist or other health care provider herein named of the group benefits payable to me. I understand I am financially responsible for charges not covered by this assignment

Employee Signature: _____

FOR FASTER PROCESSING, TAPE YOUR BILL(S) HERE OR ON REVERSE SIDE

DO NOT STAPLE