COOPERATIVE BENEFIT ADMINISTRATORS, INC.

A SUBSIDIARY OF THE NATIONAL RURAL ELECTRIC COOPERATIVE ASSOCIATION

"Notice to all parties completing this form: It is fraudulent to fill out this form with information you know to be false or to omit important facts. Criminal and or civil penalties may result from such acts."

Health Benefit Request Form

Patient Information

1. Patient's name (first name, middle initial, last name)

2. Patient's date of birth

3. Employee's name, address and telephone number
Is this a new address? ☐ Yes ☐ No

4. Patient's sex ☐ Male ☐ Female

5. Full time student? ☐ Yes ☐ No
If Yes, where?

6. ☐ Active ☐ Retired
Effective date of retirement

7. Patient's relationship to employee: ☐ Self ☐ Spouse ☐ Child ☐ Divorced ☐ Widowed

8. Patient's address (if different from employee)

9. Employee's Social Security number

10. Employer name and REA number

11. Any other medical benefits for employee, spouse or patient? (Check one of the following) ☐ Yes ☐ No
Who? ☐ Self ☐ Spouse ☐ Dependent
Give name and address of other coverage _____
If dependent or spouse, give full name: _____
Carrier phone no. _____ Group no. _____
Effective date _____ If terminated, date: _____

12. Are other family members employed? ☐ Yes ☐ No If Yes:
Name _____ Date of birth _____ Social Security number _____

13. Name and address of employer in item 12

14. Was condition related to:
A. Patient's employment ☐ Yes ☐ No B. An accident ☐ Yes ☐ No

15. If an accident:
Date _____ Description (how and where): _____
Time _____ ☐ AM ☐ PM

16. I hereby certify that the foregoing statements are true and correct to the best of my knowledge and I also authorize any hospital, physician or other person who has attended me or examined me or my dependents to disclose to Cooperative Benefit Administrators, Inc., or its authorized representatives, any and all information with respect to any illness or injury, medical history, consultation, prescriptions or treatment, and copies of all hospital or medical records. A photostatic copy of this authorization shall be considered as effective and valid as the original. I understand that the hospital benefits as provided by the plan will be paid directly to the provider of the service unless paid receipts are presented.

Patient's or authorized person's signature _____ Date _____

17. I authorize payment of medical benefits to undersigned physician or supplier for service described below or attached.

Signed (employee or authorized person) _____ Date _____

Physician or Supplier Information to be completed by physician

18. Date of sickness (first symptom) or injury (accident) or pregnancy (LMP)

19. Date first consulted you for this condition

20. Has patient ever had same or similar symptoms? ☐ Yes ☐ No

21. Name of referring physician

22. If hospitalized, give hospitalization dates: Admitted _____ Discharged _____

23. Name and address of facility where services rendered (if other than home or office)

24. Diagnosis or nature of sickness or injury. Relate diagnosis to procedure by reference to numbers 1, 2, 3 or DX code.
1.
2.
3.

25. Procedures, medical services, supplies furnished

Date of service	Place of service	CPT code	Description of service	Charges	ICD-9 code

26. Name of physician or supplier

27. Total charges

28. Amount paid

29. Balance due

30. Enter the taxpayer identifying number to be used for 1099 reporting purposes. (You are required under authority of law to furnish your taxpayer identifying number.)

31. Physician's address and telephone number
Check if new ☐

32. Patient account number

33. Physician's or supplier's signature _____ Date _____

How to Request Benefits

1. Complete the **Patient Information** section (items 1 through 16) on the reverse side of this form. If you wish to have your medical benefits paid directly to your physician, be sure to sign and date item 17. A separate form should be submitted for each family member.

2. Attach an itemized bill or have your doctor complete the **Physician or Supplier Information** section (items 18 through 33), or submit completely itemized bills. An itemized bill is one that shows the patient's name, relationship, date of service, the type of service rendered and the nature of the condition being treated, the physician's or supplier's taxpayer identifying number, and if benefits are assigned.

3. If prescription drugs are covered under your plan, please submit the receipts to include the name of the drug, quantity, the pharmacy name and number (if applicable), date of purchase, prescribing physician, prescription number, nature of sickness or injury, and the amount charged. Also indicate whether it is brand or generic.

4. Send the completed **Health Benefit Request Form** and the bills directly to the address on the back of your medical ID card.

CBA encourages electronic claim submission from health care providers.
Our WebMD payor number is 52132. For more information call 800-215-4730.