

Instructions for filing Yale Health Plan Supplemental Claims

- **A separate claim form** is needed for **each** family member.

- **Itemized bills must include:**

- patient name
- type of service
- date of service
- diagnosis
- charge for service

- **Non-Yale Health Plan pharmacy bills must include:**

- patient name
- physician name
- prescription name
- prescription number
- prescription date
- prescription charge
- pharmacy name
- pharmacy address
- pharmacy phone number

***Cash register receipts are not acceptable.**

- **Send completed claim form and bills to:**

Yale University Health Services
Business Office
55 Whitney Avenue, 2nd floor
P.O. Box 208217
New Haven, CT 06520-8217

Claims Department - 203-432-0250



Yale Health Plan Supplemental Claim Form

(Additional instructions on reverse side)

SUBSCRIBER INFORMATION

Social Security Number _____ Status faculty/staff/associate student

Name: _____
last first MI

Address (#, Street, Apt #) _____ City _____ State _____ Zip Code _____

Telephone Number: _____

PATIENT INFORMATION

Relationship of patient to subscriber

D.O.B. _____ Male Female Self Spouse Dependent

Last Name _____ First Name: _____

TYPE OF SERVICE/CLAIM

- | | | |
|---|--|--|
| <input type="checkbox"/> Blood/blood products | <input type="checkbox"/> Durable medical equipment | <input type="checkbox"/> Podiatry services |
| <input type="checkbox"/> Home health services | <input type="checkbox"/> Inpatient psychiatry | <input type="checkbox"/> Organ transplant |
| <input type="checkbox"/> Infertility | <input type="checkbox"/> Podiatry services | <input type="checkbox"/> Prescription medication |
| <input type="checkbox"/> Private duty nursing | <input type="checkbox"/> Speech therapy | <input type="checkbox"/> Substance abuse |
| <input type="checkbox"/> Other | | |

Brief description of illness/injury _____

Is injury related to:

Automobile accident	<input type="checkbox"/> yes	<input type="checkbox"/> no
Workers' Compensation claim	<input type="checkbox"/> yes	<input type="checkbox"/> no
Other liability	<input type="checkbox"/> yes	<input type="checkbox"/> no

Is patient covered by another insurance plan? Yes No

Date illness/injury began

Policy/membership #

Employee/member/subscriber name & address _____

Employer/school name & address _____

Insurance plan name & address _____

PAYMENT AUTHORIZATION

- I authorize payment of attached expenses be paid directly to the physician or provider.
- I direct Yale Health Plan to reimburse the subscriber.

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 HEALTH PLAN** for the purposes of validating and determining benefits payable in connection with this claim.

Signature: _____ Date: _____