



# Yale University Retirees Major Medical Claim Form

(Additional instructions on reverse side)

## RETIREE INFORMATION

Social Security Number \_\_\_\_\_ Date of Birth \_\_\_\_\_  Male  Female  
 Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_  
 Address (#, Street, Apt #) \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
**Telephone Number:** \_\_\_\_\_

## PATIENT INFORMATION

## RELATIONSHIP TO INSURED

Social Security Number \_\_\_\_\_  Self  Spouse  Dependent  
 Last Name \_\_\_\_\_ First Name: \_\_\_\_\_  
 D.O.B. \_\_\_\_\_  Male  Female  
 Date and Description of accident or injury (if applicable) \_\_\_\_\_  
 Dates (within the past 6 months) of any recent inpatient hospitalizations or one day surgery procedures \_\_\_\_\_  
 Please provide a copy of the Medicare Summary Notice or a copy of the billing information from the hospital or medical center where these services were provided, indicating the date services were provided.  
 Is patient covered by another insurance plan?  Yes  No If yes, please complete this section.

## SUBSCRIBER AND POLICY INFORMATION

Subscriber's Name \_\_\_\_\_ Policy # \_\_\_\_\_  
 Insurance Co. Name \_\_\_\_\_  
 Address \_\_\_\_\_ Telephone Number \_\_\_\_\_

## PAYMENT AUTHORIZATION

- I authorize payment of attached expenses be paid directly to the provider indicated.
- I authorize payment of attached expenses be paid directly to the patient.

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 University Retiree Claims processing center for the purposes of validating and determining benefits payable in connection with this claim.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## ATTACH BILLS AND RECEIPTS TO THIS FORM

MAIL TO: Yale University Retirees Processing Center  
 P.O. Box 208357  
 New Haven, CT 06520-8357

**Telephone Numbers:**  
 Benefit Questions: 203-432-8134  
 Claims Questions: 203-432-7513  
 Toll free 1-877-947-2273

**1Please allow 3 weeks from the date of mailing before calling concerning pending claims.**

## INSTRUCTIONS FOR FILING A CLAIM

### RETIREE INFORMATION:

The Yale Employee should complete this section. Please make sure Social Security Number is correct.

### PATIENT INFORMATION:

This section is to be completed by the patient. Please use a separate claim form for each retiree.

### PAYMENT AUTHORIZATION:

This section is to be completed and signed indicating if the payment is to be made to the provider or the patient.

### ATTACHMENTS REQUIRED

#### Bills must include:

Retiree name                      Diagnosis  
Patient name                    Charge for service  
CPT code                         Date of service  
Physician or provider name, address and tax ID number

#### Prescription Receipts must include:

Patient name  
Physician name  
Prescription name  
Prescription number  
Prescription date  
Prescription charge

**NOTE:** No payments will be made if Medicare Assignment has been accepted by the physician or the provider.

Retiree Medicare Patients who are submitting claims for non Medicare covered services must include a copy of the Medicare Summary Notice. No claims will be processed without the Medicare Summary Notice.

Please make copies of all bills submitted - bills are not returned to you.

Save all Medicare Summary Notices statements you receive.

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