

Supplemental Claim Form

(additional instructions on reverse side)

SUBSCRIBER INFORMATION

Member ID Number: _____ Status: faculty/staff/associate student

Name: _____ last first MI

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

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

- Chiropractic Durable medical equipment
 Home health services Prescription medication (students)
 Other

Brief description of illness or injury: _____

Is injury related to: Automobile accident yes no
Workers' Compensation claim yes no
Other liability yes no

Date illness/injury began:
Policy membership #

Is patient covered by another insurance plan? yes no

Employee member/subscriber name & address _____

Employer/school name & address _____

Insurance plan name & address _____

PAYMENT AUTHORIZATION

- I authorize payment of attached expenses to 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 YALE HEALTH PLAN for the purposes of validating and determining benefits payable in connection with this claim.

Signature: _____ Date: _____

**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
- **Student reimbursement for Non-Yale Health Plan Pharmacy Bills MUST attach copies of prescription receipts* showing the following information (employees must use the RESTAT claim form):**
 - Pharmacy Name, Address & Phone Number
 - Prescription Number
 - Drug Name
 - Drug Cost
 - Patient Name & Address
 - Fill Date
 - Quantity & Days Supply
 - Amount Paid
 - NDC Code

*Cash register receipts are not acceptable; it must be a prescription receipt.

- **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**