

## CLAIM FOR EMERGENCY MEDICAL SERVICES

**In order for your claim to be considered for payment:**

- Both sides of this form must be completed in FULL
- All itemized bill(s) and proof of payment(s) for this emergency must be attached
- This form MUST be signed
- In most cases, payment will be made to provider(s) unless proof of payment is furnished by the member or provider(s)

Patient Name:	Sex:	Birthdate:
Patient Address:	Telephone:	
Subscriber Name:	Relation to Patient:	
Subscriber Address:	Telephone:	
Place of Illness/Injury:	Incident Date:	Time:
Place of Emergency Care:	Treatment Date:	Time:
Is the Patient covered by other medical insurance?	Yes	No
If yes, Insurance Company Name:		
Name of Policy Holder/Subscriber:	Subscriber ID Number:	

Member's description of how the emergency occurred:

Was an Ambulance Used? Yes  No

Who Called the Ambulance?

**If hospitalized:**

Name of Hospital:

Admit Date: \_\_\_\_\_ Discharge Date: \_\_\_\_\_

When did you notify CCHP?

With Whom did you speak?

Name of your CCHP Primary Care Physician:

Was the injury or illness work-related? Yes  No

If yes, please attach an explanation of payment or denial from the workers' compensation carrier.

Was this injury the result of a motor vehicle accident? Yes  No

If yes, please send a copy of the auto policy face sheet for the vehicle in which the patient was riding.

If you have retained an attorney, please give the attorney's contact information.

Attorney's Name:

Attorney's Address:

Attorney's Number:

**I authorize \_\_\_\_\_ (name of providers) to release any and all information, including medical and/or hospital records pertaining to the health care services provided to me on/ between the dates listed on this Claim for Emergency Medical Services. I understand that this information is necessary to allow CCHP to process my claims for payment of these services.**

**Authorizing Signature:** *(Parent's signature, if the patient is a minor)* **Date**