



SUBSCRIBER CLAIMS SUBMITTAL FORM

IDENTIFICATION NUMBER	GROUP NUMBER	CLAIMS SHOULD BE SENT TO: Comprehensive Care Services, Inc. P.O. BOX 64008 ST. PAUL, MN 55164 651-662-5425 or 1-866-356-2425	
SUBSCRIBER'S LAST NAME	FIRST NAME INIT		
PATIENT'S LAST NAME	FIRST NAME	INIT	PATIENT'S BIRTHDATE
PATIENT'S SEX	PATIENT'S RELATIONSHIP TO SUBSCRIBER		
____ MALE ____ FEMALE	____ SELF ____ SPOUSE ____ DEPENDENT		
SUBSCRIBER'S ADDRESS: STREET	CITY	STATE	ZIP CODE
SYMPTOMS AND/OR DIAGNOSIS:			
Name of doctor or other health care professional providing service:			
Address:			
The information given above is true and correct to the best of my knowledge:			
Signature _____		Date Signed _____	
Telephone Number – Home: (____) _____		Office: (____) _____	

NOTE: Please refer to the back of this form for instructions on how to submit your claim.

IMPORTANT: PLEASE READ THE FOLLOWING INFORMATION – To meet timely filing requirements, submit your claims as soon as possible. All claims must be submitted within the timeframe indicated in your benefit book.

HOW TO SUBMIT YOUR CLAIM:

1. Complete a separate Subscriber Claim Form for each patient and for each doctor or other medical provider. Please answer all questions to get the fastest claims service.
2. Attach a copy of the itemized bill from the doctor's office. The bill should show: the diagnosis or symptoms of illness, the date, place and type of service, and the charge for each service.
3. For Medicare patients only: In addition to your itemized bill, attach a copy of your Explanation of Medicare Benefits Form.

NOTE: We cannot return your claim or materials you send with it. Please make copies for your personal files.