



SUBSCRIBER CLAIMS SUBMITTAL FORM

<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%; padding: 5px;">IDENTIFICATION NUMBER</td> <td style="width: 50%; padding: 5px;">GROUP NUMBER</td> </tr> <tr> <td style="width: 33%; padding: 5px;">SUBSCRIBER'S LAST NAME</td> <td style="width: 33%; padding: 5px;">FIRST NAME</td> <td style="width: 34%; padding: 5px;">INIT</td> </tr> </table>	IDENTIFICATION NUMBER	GROUP NUMBER	SUBSCRIBER'S LAST NAME	FIRST NAME	INIT	<p>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</p>
IDENTIFICATION NUMBER	GROUP NUMBER					
SUBSCRIBER'S LAST NAME	FIRST NAME	INIT				
<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 33%; padding: 5px;">PATIENT'S LAST NAME</td> <td style="width: 33%; padding: 5px;">FIRST NAME</td> <td style="width: 10%; padding: 5px;">INIT</td> <td style="width: 24%; padding: 5px;">PATIENT'S BIRTHDATE</td> </tr> </table>		PATIENT'S LAST NAME	FIRST NAME	INIT	PATIENT'S BIRTHDATE	
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<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 40%; padding: 5px;">SUBSCRIBER'S ADDRESS: STREET</td> <td style="width: 20%; padding: 5px;">CITY</td> <td style="width: 20%; padding: 5px;">STATE</td> <td style="width: 20%; padding: 5px;">ZIP CODE</td> </tr> </table>		SUBSCRIBER'S ADDRESS: STREET	CITY	STATE	ZIP CODE	
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:						
<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 60%;">Signature _____</td> <td style="width: 40%;">Date Signed _____</td> </tr> <tr> <td>Telephone Number – Home: (_____) _____</td> <td>Office: (_____) _____</td> </tr> </table>		Signature _____	Date Signed _____	Telephone Number – Home: (_____) _____	Office: (_____) _____	
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NOTE: Please refer to the back of this form for instructions on how to submit your claim.

IMPORTANT: PLEASE READ THE FOLLOWING INFORMATION – Claims must be submitted within 15 months of service date.

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.