



## Member Claim Form Filing Instructions

Your claim is important to us. To assist CDPHP in reimbursing your out-of-pocket expenditures properly, please complete this medical claim form.

Review the guidelines listed below to ensure all necessary information is included when filing your claim.

- Date of service** – Date service(s) occurred or date item was purchased.
- Provider's name and address** – Who delivered the service, or if a purchase, where item was purchased.
- Description of service** – Description of the service or product you received.
- Proof of Payment** – The amount you paid for the service or product.
  - Circle the dollar amount being claimed on each receipt. Do not use a highlighter.
  - If you are covered by another form of insurance for the services provided, you should submit those charges to the other insurer first. Send a copy of any Explanation of Benefits (EOBs) you receive, along with this claim form.
  - If you have dental insurance, please include a copy of your EOB with your proof of payment.

**Keep a copy of the claim form and supporting documents for your records.**

In the event you are asked to resubmit a claim due to lacking information, please enclose our letter that requested the information when you send the additional documentation.

All information should be sent to:

**CDPHP  
PO Box 66602  
Albany, NY 12206-6602**