HPFFA Medical Claim Form

Please complete one claim form per person per submission.

Check which plan applies:

☐ **(CKC / OAP)** Cigna Kelsey Care / Cigna Open Access

☐ **(CDHP)** Consumer Driven Health Plan

☐ **Medicare Retiree Plan**

☐ **Non-City**

Member Name: _____

Member DOB: _____

XXX-XX-_____

Last 4 of member's social security #

Member Address: _____

City: _____

State: _____

Zip Code: _____

☐ Please Check box if this is a new address:

Phone Number: _____

Email Address: _____

Dependent Full Name: _____

Dependent DOB: _____

Relationship: **(This claim is for?)**

☐ **Self** ☐ **Spouse** ☐ **Child** ☐ **Step-Child** ☐ **Other**

Signature: _____

Date: _____

Any person who knowingly and with intent to injure, defraud or deceive any benefits plan files a statement or claim containing any false, incomplete or misleading information may be guilty of a criminal offense.

Attach all original receipts to this form. Keep copies of all items submitted for your records.
For questions about benefits or How to File a Claim,
Call Boon-Chapman at 844-303-7562

HOW TO FILE A CLAIM

1. A fully completed claim form is required each time you submit a claim for yourself or your dependent. Complete a separate claim form for each person.
2. Attach receipts/statements from providers to this completed claim form.
3. If you were hospitalized as an in-patient, please submit the itemized hospital bill.
4. If you or a covered dependent has Consumer Driven Health Plan (CDHP) coverage, or non-city group coverage, attach your Explanation of Benefits Statement (EOB) and receipts to this completed claim form. Please obtain your EOB from www.MyCigna.com and submit with this claim.
5. Keep a copy of all items submitted. All payments issued by Boon-Chapman will be sent directly to you. Payments are not made to any health care providers.
6. Benefits for a member's covered dependents shall be determined by the same schedule which applies to the member. **Reminder** - You must file your Medical Supplement claim within **12 months** of the date of service. You must file your disability claim form within 12 **months** of the onset of the disability.

FILING A CLAIM

To MAIL a claim:
Boon-Chapman Benefits Administrators
P.O. Box 9201
Austin, Texas 78766

To EMAIL a claim:
hpffa@boonchapman.com

To DROP OFF a claim:
EPSI Benefits, Inc.
(Boon-Chapman Satellite Office)
2180 N Loop W, Suite 400
Houston, Texas 77018
Attn: Marissa Jeffries

Revised 6/27/17