HPFFA Medical Claim Form

Member Address: City: State: Zip Code: Phone Number: Email Address: Dependent Full Name: Dependent Full Name: City: State: Zip Code: Child State: Zip Code: Child Child	Please complete one	claim form per p	erson pe	r submissio	n.
Consumer Driven Health Plan XXX.XX- Member Name: Member Name: Member DOB: 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 Full Name: Dependent DOB: Relationship: (This claim is for?) Self Sopuse Child Step-Child Other Any person who knowingly and with intent to injure, defraud or deceive any benefits plan files a stalement or claim containing any false, incomplete or misleading information may be gultly of a criminal offense. Aftach 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. 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 (COHP) coverage, or non-dity 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 tile your	Check which plan applies:				
Member Name: Member Address: City: State: Zip Code: Please Check box if this is a new address: Phone Number: Email Address: Dependent Full Name: 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. Attach receipts/statements from providers to this completed claim form. 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.My/Cigna.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. Benefits for a member's covered dependents shall be determined by the same schedule which applies to the member. Reminder - You must file your		Consumer Driven	Me		n Non-City
Please Check box if this is a new address: Phone Number: Email Address:	Member Name:	Member DOB:	<u> </u>		per's social security #
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	Member Address:	City:		State:	Zip Code:
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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.	Describe for a consistent and account described by delegation	ed by the same schedule wh	ich applies to	the member. Remin	nder - You must file your
	Medical Supplement claim within 12 months of the date of serv	rice. You must file your disal	oility claim form	m 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