

Mail to:
CBA Blue
P.O. Box 2365
South Burlington, VT 05407-2365
Fax to: (802) 864-8115



Medical Claim Form Instructions

Employee Information:

1. Last Name
2. First Name
3. Middle Initial
4. Street Address (Mailing Address) 4a. Apartment or Unit Number
5. Birth Date
6. Marital Status (Single, Married, Divorced)
7. City
8. State
9. Zip
10. Home Phone
11. Alternate Phone (cellular, office, or other)
12. Email Address
13. Employer Name
14. Group Number (five digit number from your ID card)
15. Member Identification Number (include the three leading alpha character and nine digit suffix)

Patient Information (if you are submitting claims for more than one patient, use multiple forms):

16. Patient's Last Name
17. Patient's First Name
18. Patient's Middle Initial
19. Patient's Street Address (if different from Employee) 19a. Apartment or Unit Number
20. Patient's City (if different from Employee)
21. Patient's Zip (if different from Employee)
22. Patient's Zip (if different from Employee)
23. Patient's Date of Birth
24. Patient's Sex
25. Patient's Relationship to Employee (if "other" – please describe)
26. Patient's Home Phone
27. Patients Alternate Phone (cellular, office, or other)
28. Provide Other Insurance Information If

Claim Information:

29. Indicate if claim was the result of an accidental injury, check yes or no 29a. & 29b. Date/Details Injury
30. If Injury, indicate if work related
31. Date(s) Of Service of Claim(s) being submitted for reimbursement
32. Provider(s) of Service for claims being submitted
33. Indicate where reimbursement should be sent

Sign form and remit to CBA Blue to the address or fax number listed at the top of this form. Please include an itemized bill(s) from the provider(s) of service. Claims filed for prescription reimbursement should include the pharmacy receipt (not cash register receipt. Attach prescriptions to a separate piece of paper.