



CDPHP UNIVERSAL BENEFITS, INC.
500 Patroon Creek Blvd. • Albany, NY 12206-1057

*** MAIL: COMPLETED FORM TOGETHER WITH ALL ITEMIZED BILLS TO ADDRESS SHOWN ABOVE.
IF CLAIM FORM IS NOT COMPLETE OR IF ANY OF THE ITEMIZED BILLS REQUIRE FURTHER INFORMATION, SUCH MATERIAL MAY BE RETURNED TO YOU WITH ADDITIONAL INSTRUCTIONS. OTHERWISE ALL ITEMIZED BILLS WILL BE RETAINED BY US AND CANNOT BE RETURNED.

ALL QUESTIONS MUST BE ANSWERED. PLEASE PRINT OR TYPE.

ENTER NAMES AS SHOWN ON YOUR CDPHP IDENTIFICATION CARD.

1 SUBSCRIBER'S LAST NAME FIRST NAME INITIAL CDPHP ID. NO. GROUP NUMBER
ADDRESS-NUMBER AND STREET CITY STATE ZIP CODE
Please Check Here If This Is A New Address

2 PATIENT'S LAST NAME FIRST NAME INITIAL DATE OF BIRTH SEX PATIENT'S RELATIONSHIP TO SUBSCRIBER
MONTH DAY YEAR MALE FEMALE SELF CHILD SPOUSE

3 OTHER HEALTH INSURANCE COVERAGE:
DOES PATIENT HAVE ADDITIONAL HEALTH INSURANCE COVERAGE THROUGH EMPLOYER OR OTHER GROUP HEALTH INSURANCE? YES NO IF YES, PLEASE COMPLETE
NAME OF OTHER POLICY HOLDER POLICY OR IDENTIFICATION NUMBER
POLICY EFFECTIVE DATE TYPE OF COVERAGE OTHER POLICY HOLDER'S BIRTH DATE
SINGLE FAMILY
NAME AND ADDRESS OF OTHER INSURANCE CARRIER

4 MEDICARE COVERAGE: IS THE PATIENT ENTITLED TO MEDICARE? YES NO IF YES, PLEASE COMPLETE.
PATIENT'S MEDICARE IDENTIFICATION NUMBER
MEDICARE PART A (HOSPITAL INSURANCE) EFFECTIVE DATE
MEDICARE PART B (MEDICAL INSURANCE) EFFECTIVE DATE
IS THE PATIENT EMPLOYED? YES NO IS THE SPOUSE EMPLOYED? YES NO

5 WERE EXPENSES DUE TO AN ACCIDENTAL INJURY: YES NO IF YES, PLEASE COMPLETE.
TYPE OF ACCIDENT: WORK AUTO MOTORCYCLE OTHER DATE OF ACCIDENT

SUBSCRIBER'S SIGNATURE AND ITEMIZATION OF BILLS REQUIRED ON THE OTHER SIDE.

