Community Health Claim Request

Please Return Completed Form Via Facsimile (412) 429-7078 Attn: CHC Claim Request

❑ Member Notification	❑ Attorney Inquiry	❑ Other:
Today's date:	Person Completing Form:	

PATIENT INFORMATION

Patient Last Name:	First:	Middle:	Member ID:
Is the Patient the Policy Holder?	❑ Yes ❑ No	If No, Policy Holder Name:	
Date of Birth:	Home Phone No.:	E-Mail Address:	
Street address:	City:	State:	Zip Code:

Accident, Injury, Illness Occurred: (please check one box):

❑ Home ❑ Work ❑ Motor Vehicle / Motorcycle

❑ Another's Home – Provide Name and Address:

❑ Public Place – Provide Name and Address:

❑ Other – Provide Details:

Describe the physical injury (specify right or left) and how it happened:

Date of Accident:	Date of First Treatment:	Treatment End Date:

ATTORNEY INFORMATION

Is an attorney involved? ❑ Yes ❑ No	Name of Firm:		
Attorney's Name:	Phone No.:	Fax No.:	
Street Address:	City:	State:	Zip Code:
Pæ•ÁÙ˘ ãáà^^}Áã^åÑÁÁÁÁÁ ❑ Yes ❑ No	Docket No.:		

ADDITIONAL INFORMATION / NOTES

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❑ Yes ❑ No

❑ This is a request for information related to payment of claims for services received including additional information located on a claim form. (i.e., billed amount, general procedure code, general diagnosis code, claim payments, ect.)

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