CHRISTIAN BROTHERS EMPLOYEE BENEFIT TRUST
CLAIM FORM

It is strongly preferred that providers file electronically or use standardized HCFA or UB forms to submit claims. If you need to submit a claim, please complete the top section of the form with all information. The provider may complete the bottom section of this form or you may attach the billing from the provider if all required information is included on the billing.

If complete information is not provided, it may delay the payment of your claim. Please mail the completed form and original materials to:

Christian Brothers Employee Benefit Trust
1205 Windham Parkway
Romeoville, IL 60446

PATIENT INFORMATION		Insured Privacy ID Number:
Patient Name:	Patient Date of Birth:	Insured Name:
Patient Address:	Patient Relationship to Insured:	Insured Address:
City, State, Zip:	Insured Telephone Number:	City, State, Zip:
	Is Patient Condition Related to: Employment? Yes ☐ No ☐	Insured Date of Birth:
		Insured Account Number from ID Card:
Patient or Authorized Person's Signature: I authorize the release of any medical or other information necessary to process this claim Signed _____ Date _____		Insured's Signature: I authorize payment of medical benefits to the undersigned physician or supplier for services described below. Signed _____

PROVIDER INFORMATION	
Diagnosis or Nature of Illness or Injury: 1. _____.____ 3. _____.____ 2. _____.____ 4. _____.____	

Dates of Service	Place of Service	Procedures Services or Supplies CPT/HCPCS	Modifier	Diagnosis Pointer	$ Charges	Days or Units	Rendering Provider NPI #

FEDERAL TAX ID #	PATIENT'S ACCT #	ACCEPT ASSIGNMENT Yes ☐ No ☐	TOTAL CHARGE	AMOUNT PAID	BALANCE DUE

Signature of Physician or Supplier Including Degrees or Credentials (I certify that all information is accurate and the patient is liable for all amounts billed.) Signed Date	**Service Facility Location Information**	**Billing Provider Info & Phone Number**