CPM, Inc.
Member Claim Form

Filing Requirements:

- Complete a separate claim form for each covered family member.
- Enclose itemized receipts and make copies for your records. **See Section IV for REQUIRED information**.
- Do not file a claim if the provider is filing for the same services.
- **Claims not received on a 1500, UB or ADA form will be considered as out-of-network only**.
- Attach Explanation of Benefits if these services are covered by another insurance policy.
- Claims must be filed within 12 months from the date services were received, or they will be denied.
- Please see Section V for mailing information

Any claim filed without the required documentation listed above will be returned.

SECTION I: Patient Information	Please enter the number from your ID card.		
Subscriber ID Number:			
Patient's Last Name:		**First Name**	**Middle Initial**
Date Of Birth:	**Sex: M F**	**Relationship To Subscriber:**	Self Child Spouse Other:

SECTION II: Mailing Information	_______ Please check here if your address has changed.	
Subscriber Name:____		
Address (Line 1):____		
Address (Line 2):____		
City:	State:	Zip Code:

SECTION III: Other Insurance Information Please complete the information below if the patient is covered by another health insurance policy.	
Does the patient have other insurance? Yes No	Other health insurance company name:
Other policy number:	Other policy holder's name:
Please Complete the information below if the patient is covered by Medicare:	
Medicare health insurance claim number:	**Is patient Eligible for ______Part A ______Part A and B ______Part B**

PLEASE NOTE: If your other insurance or Medicare policy is primary, you must attach a copy of the Explanation of benefits from that insurer. Your claim cannot be processed without the information.

SECTION IV: Services and Supplies To Be Considered For Reimbursement

These may include medical appliances, diabetic supplies, immunizations or out-of-network services.

Corporate Plan Management requires that procedure codes on the itemized receipt be supplied by the provider of the service. Claims or itemized receipts received without the information below will be RETURNED.

1. The date of service;
2. The name, address, telephone number and tax identification number of the provider of the services or supplies;
3. The place where the services were rendered;
4. The diagnosis and procedure codes;
5. The amount of charges;
6. The name of the Plan;
7. The name of the covered employee; and
8. The name of the patient.

Date of Service (MM-DD-YY)	Procedure Codes or Description of Services/Supplies	Diagnosis Codes or Symptoms you Sought Treatment For	Charge
01-05-14	EXAMPLE: Office Visit	Cold and Flu Symptoms	54.00

Section V: Mailing Information

MAIL THIS FORM , ITEMIZED RECEIPTS AND EXPLANATION OF BENEFITS *(if applicable)* TO:

CPM, Inc.
1220 SW Executive Dr.
Topeka, Kansas 66615

DID YOU REMEMBER TO:

- Attach the Explanation of Benefits, if applicable?
- Attach itemized receipts that contain the 8 items list above?
- Provide your signature below?
- Keep a copy of this form and your receipts?

I certify that the information on this corm is correct and the expenses incurred were necessary for the services filed

Signature: **Date:** **Daytime Phone Number:**

I certify that the information on this corm is correct and the expenses incurred were necessary for the services filed

Signature of Dependent___________________________________ **Date:** _____________**Daytime Phone Number:** __________________
(Dependent over age 18)