Health Claims
1205 Windham Parkway
Romeoville, IL 60446
630.378.2900 / 630.378.2504 fax
HealthCustomerService@CBServices.org

Health Reimbursement Form

It is strongly preferred that providers file electronically or use standardized HCFA, UB, Dental, or Vision claim forms to submit claims. If you need to submit a claim, please complete the top section of the form with all information. Proper billing should include provider's name, tax identification number, NPI number, itemized charges, service descriptions and applicable CPT codes, ICD 10, and CDT diagnosis codes. Please attach the billing from the provider. If all required information is not included on the billing additional information may be requested.

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 Services/Health Claims
1205 Windham Parkway
Romeoville, IL 60446

Patient Information

Patient Name (Last, First, Middle Initial)

Patient Date of Birth

Patient Home Street Address

Patient City

State

Zip Code

Patient Relationship to Insured

Is Patient Condition Related to Employment? ☐ Yes ☐ No

Patient or Authorized Person's Signature. I authorize the release of any medical or other information necessary to process this claim.

Signature

Date

Insured Information

Insured Privacy ID Number

Insured Telephone Number

Insured Name (Last, First, Middle Initial)

Insured Street Address

Insured City

State

Zip Code

Insured Date of Birth

Insured Group Number from ID Card

Insured's Signature. I authorize payment of medical/dental/vision benefits to the undersigned physician or supplier for services described below.

Signature

Date

Provider Information

Attach Bill/Claim