



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

Reimbursement 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. Proper billing should include provider's name, tax identification number, NPI number, itemized charges, service descriptions and applicable CPT codes and ICD 10 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 Solutions
1205 Windham Parkway
Romeoville, IL 60446

Patient Information

Patient Name (Last, First, Middle Initial)		Patient Date of Birth	Patient Home Street Address	
<input type="text"/>		<input type="text"/>	<input type="text"/>	
Patient City	State	Zip Code	Patient Relationship to Insured	Is Patient Condition Related to Employment? <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	

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

Signature	Date
<input type="text"/>	<input type="text"/>

Insured Information

Insured Privacy ID Number	Insured Telephone Number	Insured Name (Last, First, Middle Initial)		
<input type="text"/>	<input type="text"/>	<input type="text"/>		
Insured Street Address		Insured City	State	Zip Code
<input type="text"/>		<input type="text"/>	<input type="text"/>	<input type="text"/>
Insured Date of Birth	Insured Group Number from ID Card			
<input type="text"/>	<input type="text"/>			

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

Signature	Date
<input type="text"/>	<input type="text"/>

Provider Information

Attach Bill/Claim